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Part 1

MEDICARE CATASTROPHIC PROTECTION ACT OF 1987

MAY 22, 1987.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

together with

ADDITIONAL AND DISSENTING VIEWS

[To accompany H.R. 2470 which on May 19, 1987, was referred jointly to the Committee on Energy and Commerce, and the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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I. Introduction

PURPOSE

The Committee bill, H.R. 2470, the Medicare Catastrophic Protection Act of 1987, would provide acute care catastrophic protection for hospital and physician services and improve coverage under the Medicare program in several ways. This bill would protect Medicare beneficiaries from catastrophic hospital expenses by limiting beneficiary liability to one hospital deductible in a calendar year. It would limit beneficiary expenses for stays in a skilled nursing facility to seven days of coinsurance in a calendar year. Hospice reimbursement would be extended beyond the current 210 day limit to assure that terminally ill Medicare beneficiaries would have access to the hospice benefit.

The bill would also limit Medicare beneficiary liability for covered Part B services. This limit would be approximately $1,043 in 1988 and increase in subsequent years by the same percentage increase as provided for Social Security benefits. The bill would also improve the Medicare benefit with regard to home health and outpatient mental health services. Another provision of the bill would require states to pay the Medicare premium, deductible and coinsurance amounts for all elderly and disabled with incomes up to the Federal Census Bureau poverty threshold. Changes concerning the Federal standards and requirements for Medicare Supplemental Insurance (medigap) policies are also included in the bill in order to protect Medicare beneficiaries who purchase these policies.

Lastly, the bill provides for financing of these benefits in a budget neutral manner. Medicare beneficiaries who file a Federal income tax return would pay a supplemental premium based on their adjusted gross income beginning in 1988. Further, in 1990 and 1991 a small additional premium amount would be added to Medi-

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care beneficiaries' current Part B premium. Medicare beneficiaries in American Commonwealths and Territories would also pay an additional premium beyond the current law Medicare Part B premium, as would individuals who are not eligible for Part A of Medicare but purchase Part B of Medicare.

SHORT SUMMARY

Provisions relating to part A

I. Inpatient hospital services

a. Inpatient hospital deductible.—The inpatient hospital deductible would apply only to a beneficiary's first period of continuous hospitalization beginning in a period of continuous hospitalization beginning in a calendar year. The deductible would be indexed to the Social Security cost-of-living adjustment (COLA) each year. This deductible is estimated to be approximately $541 in 1988.

b. Elimination of day limitation on inpatient hospital services.—The Medicare limits on payment for days of inpatient hospital care (90 days of inpatient hospital care plus a lifetime reserve of 60 days) would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services. The 190-day lifetime limit on inpatient psychiatric hospital services would be retained.

c. Elimination of coinsurance amounts for inpatient hospital services.—The current hospital inpatient coinsurance amounts for days 61 through 90 and coinsurance for the 60 lifetime reserve days would be eliminated.

d. Elimination of spell of illness.—The "spell of illness" methodology would be eliminated for determining: the number of hospital days Medicare would cover, the skilled nursing facility coinsurance and the Part A blood deductible.

e. Adjustments in payments for inpatient hospital services.—When adjusting the Medicare hospital payment system, the Secretary of Health and Human Services (HHS) would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hosptials.

II. Extended care services (skilled nursing facility)

a. *Coinsurance on first seven days.*—Beneficiaries would be required to pay coinsurance amounts for the first seven days of such services.

b. *Coinsurance equal to 20 percent.*—The coinsurance amount per day would be equal to 20 percent of the national average per diem Medicare reasonable cost for skilled nursing facility (SNF) services in the succeeding year. The coinsurance amount is estimated to be approximately $24 per day in 1988.

c. *Cover 150 days of care.*—The Medicare program would cover 150 days, instead of the current 100 days, of skilled nursing care services in a calendar year.

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d. *Prior hospitalization requirement.*—The three-day prior hospitalization requirement for skilled nursing facility benefits would be eliminated effective for skilled nursing facility stays beginning on or after January 1, 1989.

III. Hospice care

a. *Extending day limit on hospice care.*—The Medicare program would extend the hospice benefit, and reimburse a hospice, beyond the current 210-day benefit period if the beneficiary's physician or hospice director recertified that the beneficiary was still terminally ill.

IV. Blood deductible

a. *Change blood deductible requirement.*—A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year. The blood deductible could be met by replacing the blood, in accordance with regulations.

V. Transfer of home health benefits to part B

a. *Transfer of home health benefits to Part B.*—Beginning on January 1, 1989, home health care benefits would be a covered benefit under Part B only, except for individuals eligible for Part A but not enrolled in Part B. There would be no change in coverage or reimbursement policies for these home health benefits.

VI. Financing

a. *Supplemental premium.*—A supplemental premium would be calculated from a Medicare Part A eligible individual's adjusted gross income for tax purposes. This supplemental premium would depend on income, and would be determined from a table in the tax form instructions. However, adjusted gross income would not be increased. The supplemental premium would be adjusted to reflect the increase in the cost of Medicare benefits. The supplemental premium would be mandated and not treated as a deductible medical expense. The maximum supplemental premium an individual would pay in 1988 would be approximately $580 and in 1992, approximately $930.

Individuals not required to pay the supplemental premium would include: (1) any individual who is entitled to benefits under Part A of Medicare solely by reason of the payment of a premium for Part A, (2) any individual who is required to pay an additional Part B premium by virtue of being a resident of an American Commonwealth or Territory, (3) any individual who is required to pay an additional Part B premium because the individual is entitled only to Part B benefits, and (4) any qualified nonresident.

VI. Effective date

a. *Effective date.*—The above Part A benefits would be effective for services provided on or after January 1, 1988. Tax changes would apply to taxable years ending after December 31, 1987.

Provisions relating to part B

I. Limitation on Medicare out-of-pocket expenses under part B

a. *Limit out-of-pocket expenses.*—After a Medicare beneficiary had incurred out-of-pocket Part B covered expenses in a calendar year which exceeded the Part B catastrophic limit, (a) Medicare would be required to pay 100 percent of reasonable charges (or in some cases, the reasonable costs) for any additional Part B covered services in the year, and (b) no further deductibles would be required.

Out-of-pocket Part B expenses would be defined to include the Part B $75 deductible, the Part B blood deductible, $250 of reimburseable mental health services and the 20-percent coinsurance required to be paid by beneficiaries for Part B benefits.

The Part B catastrophic limit would be $1,043 in 1989 and increased by the Social Security COLA in succeeding years.

For prepaid health care organizations paid on the basis of aggregate reasonable cost, the Secretary would be required to provide for an appropriate adjustment to their payment amounts to reflect the increase in protection as if payment were made on an individual-by-individual basis.

b. *Institutional provider limitation.*—Institutional providers with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider.

II. Home health services

a. *Home health.*—The "intermittent" skilled nursing care definition for home health services would be expanded so that "daily" would be defined as up seven days a week for up to 35 days in any given period, instead of five days a week for up to two or three weeks. A subsequent extension could be provided based on a physician's certification of exceptional circumstances requiring the continuation of services beyond the 35 days.

III. Outpatient mental health services

a. *Outpatient mental health.*—The present law maximum Medicare reimbursement for mental health outpatient services would be raised from the current limit of $250 ot $1,000 per calendar year. The coinsurance requirement would remain the same.

IV. Mailing notice requirement and physician directories

a. *Mailing notice requirement and physician directories.*—The Secretary would be required to prepare an annual notice to be sent to all Medicare beneficiaries that would provide a simple, clear explanation of Medicare benefits. This notice would also include an explanation of the limits of the Medicare and Medicaid programs with regard to long term care benefits. In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January, 1988.

V. Providing additional medical assistance for indigent Medicare beneficiaries

a. Providing Additional Assistance for Indigent Medicare Beneficiaries.—The Federal Supplemental Security Income program (SSI) would be amended to establish a separate category of elderly and disabled for whom state Medicaid programs, including states operating under section 1115(a) waivers, would be required to pay the Medicare premium, deductibles and coinsurance amounts.

All elderly and disabled individuals with incomes up to the Federal Census Bureau poverty threshold level would be entitled to participate in this program. The current Federal matching requirements would apply to this provision. The States would be required to begin paying monthly premiums for months beginning with July, 1988, and for items and services provided on and after July 1, 1988.

VI Part B premium adjustment

a. Part B premium adjustment.—The Part B premium would be ajdusted so that $1,00 per month would be added to the current law Part B monthly premium in 1990; and a net amount equal to approximately $1.50 per month would be added in 1991 and 1992. Thereafter, the Part B premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits

b. Part B premium for residents of U.S. Commonwealths and Territories.—Medicare beneficiaries residing in the American Territories and Commonwealths would be required to pay an additional Part B premium approximately equal to the average per capita value of the new catastrophic benefits contained in this bill.

This amount would be divided by twelve, and one-twelfth would be added to the current law monthly Part B premium beneficiaries now pay. In subsequent years the monthly premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits.

c. Part B premium for individuals enrolled under part B but not entitled to benefits under part A.—Medicare beneficiaries who are not entitled to Part A benefits but who voluntarily enroll in Part B would be required to pay an additional Part B premium equal to the average per capital value of the new catastrophic benefits contained in this bill.

This amount would be divided by twelve, and one-twelfth would be added to the current law monthly Part B premium beneficiaries now pay. In subsequent years the monthly premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits.

VII. Medicare supplemental health insurance policies

a. Establishment of new medigap standards.—The Secretary, taking into consideration any recommendations developed by the National Association of Insurance Commissioners and the Medicare catastrophic legislation passed by the Congress, would be required to report to Congress, within 1500 days after enactment of the legislation, his recommendations for changes that would be made in

the Federal requirements for certification of Medicare supplemental policies.

b. Required mailing of notice.—Companies that issue Medicare supplemental policies that are in effect on January 1, 1988, would be required by January 31, 1988, on a one-time basis, to send a letter to their policyholders who are entitled to Medicare, explaining the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the medigap policies and the cost of these premiums.

c. *Required submission of advertising.*—Companies that issue Medicare supplemental policies would be required to submit their advertising files to each State Insurance Commission, in which they do business, for review as to whether their marketing practices comply with State law with respect to advertising used on or after January 1, 1988.

d. *Transition for current policies.*—Federal penalties for noncompliance with the substantial duplication of health benefits requirement contained in section 1882(d)(3)(A) would be suspended for two years, beginning January 1, 1988, and ending December 31, 1989, for existing Medicare supplemental policies, but new policies would still be subject to the penalties and fines of not more than $25,000 or imprisonment for not more than five years, or both, after Medicare catastrophic legislation is enacted.

VIII. Extension of social HMO demonstration project

a. *Social HMO waiver.*—The current Health Care Financing Administration waiver would be extended through September, 1992, for the four Special Health Maintenance Organization demonstration projects.

IX. Study on comprehensive medical coverage under the Medicare Program

a. *Comprehensive Medicare coverage study.*—The General Accounting Office would be required to conduct a study to assess the need for, and costs of, including comprehensive medical coverage under the Medicare program, such as extended-care services, routine dental and eye examinations, and long-term care services.

X. Research on long-term care for Medicare beneficiaries

a. *Long-term care research.*—Five million dollars would be authorized for each of the next five years for the Secretary of the Department of Health and Human Services to support research on long-term care. The research would focus on issues of delivering and financing of long-term care services.

XI. Effective date

a. *Effective date.*—The effective dates for Part B benefits would be for services furnished on or after January 1, 1989. The additional premium for individuals who voluntarily enroll in Medicare would begin in January 1990. The additional premium for Medicare beneficiaries residing in the Commonwealths and Terrorities would begin in January 1988. The additional premium for those in-

dividuals not entitled to Part A benefits except by payment of a premium but who buy Part B would begin in January 1989.

BACKGROUND AND NEED FOR LEGISLATION

The Committee bill, H.R. 2470, would protect Medicare beneficiaries from catastrophic expenses associated with covered hospital and physician services. The need for this bill is evident, as Medicare, the Federal program designed to meet the acute medical care needs of older Americans does not cover truly catastrophic hospital and physician expenses.

Despite the trend toward generally improved health status of the elderly, their needs for health care remain substantial. Greater life expectancy merely postpones the inevitable need for care of chronic and terminal illnesses. Many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. For example, nearly half report having arthritis, forty percent report high blood pressure, and nearly one-third report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income. A recent study found that the six percent of Medicare beneficiaries who died in 1978 accounted for twenty eight percent of Medicare expenditures, suggesting that Medicare beneficiaries in their last year of life are severely or chronically ill.

Expenditures for personal health care services for the elderly nearly tripled between 1977 and 1984, rising from $43 billion to an estimated $120 billion. Per capita spending rose an average of thirteen percent annually during those years, from $1,785 to $4,202.

Fairly extensive coverage is provided for short-term hospital stays under Medicare Part A. Coverage for long-term hospital stays is less adequate. These long stays are subject to significant coinsurance charges. Further a beneficiary may potentially exhaust all benefits and be required to pay thousands of dollars of hospital and physician charges. In addition to a monthly premium, beneficiaries enrolled in Part B are liable for certain charges in connection with their use of physicians and other charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and the twenty percent coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's determination of the reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charges.

Even though Medicare in 1987 will spend close to $80 billion on medicare care, the elderly will also have out-of-pocket expenses of over $30 billion, not including long-term care. Out-of-pocket expenses by the elderly represent the difference between total health expenditures by the elderly and known third party payments. These out-of-pocket payments include Medicare copayments (less any benefits paid by so-called "Medigap" plans), collected reasonable charge reductions, net private health insurance copayments, and the purchase of care not covered by any third party. It is important to note that direct out-of-pocket payments to providers are

not the only expenditures by the aged for health care. The aged also pay Medicare Supplementary Medical Insurance (Part B) and private health insurance premiums that are not defined as out-of-pocket expenditures. Private health insurance, including Medigap policies, covers an additional estimated seven percent ($304 per capita) of personal health expenditures for the elderly.

About eight million senior citizens will spend some time in the hospital this year. For those with one inpatient stay the average out-of-pocket liability will run about $1,335, but for those with lengthy hospital stays the expenses can add up to thousands of dollars resulting in financial ruin.

For some elderly the amount of health care expenses paid out of pocket can be a greater burden than for others, depending on their income. In 1986, over twenty percent of senior citizens had to spend at least fifteen percent of their income on medicare care, while seven percent spent twenty-five percent or more of their income paying medical bills.

While Social Security payments have lifted many of the elderly out of poverty, nineteen percent or about six million, have incomes below the poverty threshold of $5,000 and forty-nine percent of older Americans still have income below $10,000. Having to spend twenty-five percent of $10,000 of income on medical expenses is truly catastrophic.

It has been argued that Medigap or private supplemental insurance policies are already meeting the catastrophic medical needs of the elderly. While seventy percent of the elderly buy Medigap insurance, many of these policies, according to a recent General Accounting Office study (GAO/HRD–87–8), are very inefficient supplements. Many return, on average, only sixty cents on the dollar in benefits. In other words, seniors paid more than a billion dollars in premiums than the policies paid out in benefits. In addition, many policies have pre-existing clauses which prevent seniors from filing claims for needed medical care. The Medicare program has only two percent administrative costs, which means it can pay out ninety-eight percent in benefits without denying benefits for those with pre-existing conditions.

Furthermore, the likelihood of a Medicare beneficiary having a supplemental insurance policy increases with income. Low-income elderly, therefore, are often without supplemental policies that could meet some of their catastrophic medical needs.

Given the rising cost of medical care, the aging of the population and the growing disparity between what Medicare will and will not pay for, it is evident that the Medicare program needs to be expended to fill the acute care gaps in coverage, which can lead to financial bankruptcy by Medicare beneficiaries.

II. Explanation and Justification

TITLE 1—PROVISIONS RELATING TO PART A OF MEDICARE

Sec. 101. Inpatient hospital services

Present law

(a) Application of inpatient hospital deductible on a calendar year basis and limitation to one deductible each year.— Under current

law beneficiaries are required to pay a first day hospital deductible for inpatient hospital services furnished in each "spell of illness" ($520 in 1987). A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was neither an inpatient of a hospital nor a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission.

(b) Elimination of general day limitation on inpatient hospital services.— Under current law a beneficiary is entitled to inpatient hospital services for up to 90 days in any one "spell of illness." In addition to the 90 days of hospital care, each beneficiary has a lifetime reserve of 60 days of added coverage after the 90 days have been exhausted. After a beneficiary has received 90 days of care in a "spell of illness" and exhausted the 60 lifetime reserve days, Medicare does not provide for further hospital reimbursement and the beneficiary is responsible for all hospital charges.

Under current law, there are separate day limitation restrictions on inpatient psychiatric hospital care. If an individual is an inpatient of a participating psychiatric hospital on the first day for which the beneficiary is entitled to hospital insurance benefits, the days on which the beneficiary was an inpatient of a psychiatric hospital in the 150-day period immediately before this first day are deducted from the 150 days of inpatient psychiatric services for which the beneficiary is otherwise entitled to have payment made during the first "spell of illness", if these services were furnished to the beneficiary in a psychiatric hospital. Further, payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during a beneficiary's lifetime.

(c) Elimination of coinsurance amounts for inpatient hospital services.—Under current law beneficiaries are required to pay coinsurance when inpatient hospital services are received for more than 60 days during a "spell of illness." The beneficiary is responsible for a coinsurance amount for each day after the 60th and through the 90th day and by law the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible ($130 a day in 1987). There is also a coinsurance amount for each day, after the 90th day and through the 150th day in any "spell of illness", that is chargeable against the individual's 60 lifetime reserve days. The coinsurance for these days by law is equal to one-half of the inpatient hospital deductible ($260 a day in 1987).

(d) Indexing of inpatient hospital deductible.—Under current law the amount of the hospital deductible is revised each January and is equal to the inpatient hospital deductible for the preceeding calendar year, updated by the same percentage that applies to prospective payment (PPS) rates and adjusted to reflect changes in real case mix.

(e) Determination of part A premium.—Under current law individuals age 65 or over who are not entitled to Hospital Insurance (Part A) benefits may voluntarily enroll in the Hospital Insurance program if they pay a monthly premium. The premium currently

does not reflect the actuarial value of the Hospital Insurance benefit. Instead, the Secretary is required to calculate the premium each year under a formula that is equal to $33 multipled by the ratio of the inpatient hospital deductible for the subsequent calendar year to the deductible promulgated for 1973.

(f) Adjusting payments for inpatient hospital services.—Under current law, hospitals in general are paid on the basis of a prospective payment system in which Medicare pays a prospective amount for each Medicare discharge based on one of the 470 different diagnosis-related groups (DRGs). The DRG payments are based on the assumption that Medicare will cover at most 90 days of covered hospital services in a "spell of illness" and 60 lifetime reserve days.

The Committee believes there is a need for acute hospital care catastrophic coverage. Either million senior citizens will spend some time in the hospital this year. For the fifteen percent of Medicare beneficiaries who will have one inpatient stay the average out-of-pocket liability will run about $1,165. For the seven percent who will have two or more stays in the hospital the average out-of-pocket cost will amount to over $2,000. For the half a percent of beneficiaries who have lengthy hospital stays requiring the payment of coinsurance amounts, the average out-of-pocket expenses will average approximately $7,600. For low and moderate income elderly such costs can deplete lifetime savings, leaving substantial debts.

In 1986, over twenty percent of senior citizens had to spend at least fifteen percent of their income on their medical care, which seven percent were forced to spend twenty five percent or more of their income paying medical bills.

The Committee also believes complex features of the program such as the "spell of illness" methodology should be eliminated. For these reasons the Subcommittee has proposed the following changes in the Medicare program to eliminate the potential for financial ruin resulting from lengthy hospital stays and to reduce the complexity of the program.

Because the hospital benefit will be extended to 365 days of hospital care from the current limit of 150 days in a calendar year, the Committee believes there is a need to give the Secretary discretion to adjust, if necessary, the DRG payments, as well as the targeted amounts, outlier cutoff points and weighting factors in determining payments to hospitals.

Explanation of provisions

(a) Application of inpatient hospital deductible on a calendar year basis and limitation to one deductible each year.—A beneficiary would be required to pay only one hospital deductible in a calendar year no matter how many times the beneficiary was admitted to a hospital during the calendar year. The "spell of illness" methodology would be eliminated for determining the number of hospital deductibles, the number of days Medicare would cover, and the hospital coinsurance amounts. A new deductible would not be required if the hospitalization began in one calendar year and continued into the following year, but a deductible would be required if the beneficiary reentered the hospital later in the second year.

(b) Elimination of general day limitation on inpatient hospital services.—The Medicare limits on payment for 150 days of inpatient hospital care would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services in a calendar year. However, the current 190 day lifetime limit and 150 day rule on inpatient psychiatric hospital services would be retained.

(c) Elimination of coinsurance amounts for hospital services.—The current requirement for the payment of hospital coinsurance amounts for inpatient days 61 through 90 and the 60 lifetime reserve days would be eliminated.

(d) Indexing of inpatient hospital deductible.—The method of determining the inpatient hospital deductible beginning in 1988 would be changed so that it would equal the preceeding year's deductible, increased by the cost-of-living adjustment to Social Security benefits. Not later than November 15 of each year, beginning in 1987, the Secretary would be required to promulgate the inpatient hospital deductible for the suceeding year.

(e) Determination of part A premium.—The Secretary would be required to establish a Part A premium for those who voluntarily enroll in Part A equal to the actuarial value of the Part A benefit. The actuarial value would equal one-twelfth of the estimated average per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year. The Secretary would be required to determine and promulgate the premium during September of each year and issue a public statement setting forth the actuarial assumptions and basis employed in determining the actuarial rate.

(f) Adjustment in payments for inpatient hospital services.—When adjusting the Medicare hospital payment system, the Secretary would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals.

Effective date

(a) and (d). The changes relating to the deductible would be for inpatient hospital services furnished on or after January 1, 1988, and succeeding years. However, in the case of an individual for whom a spell of illness began before January 1, 1988, and had not yet ended as of such date, the deductible would not apply to services furnished during that spell of illness during 1988 or 1989.

(b) and (c) The changes relating to the extension of benefits and coinsurance would be effective for inpatient hospital services furnished on or after January 1, 1988.

(e) The changes relating to the Part A premium would apply to premiums for months beginning with January 1, 1988.

(f) The Secretary, when appropriate, would adjust inpatient hospital payments to hospitals for services furnished on or after January 1, 1988.

Sec. 102. Extended care services

Present law

(a) Coinsurance rate of 20 percent of national average per diem for services furnished during first 7 days of each calendar year.—Under current law a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of extended care services furnished during a "spell of illness" ($65 a day in 1987).

The Committee believes the current method of calculating the coinsurance amount has resulted in an excessive coinsurance requirement. In parts of the country the daily coinsurance amount is now greater than the cost of the day's stay in the skilled nursing facility.

(b) Extension to 150 days in each calendar year.—Under current law a beneficiary is entitled to post-hospital extended care services in a qualified skilled nursing facility for up to 100 days in any one "spell of illness."

It is the belief of the Committee that the "spell of illness" methodology for determining skilled nursing facility coinsurance is an unnecessary complexity which can become a financial barrier to a beneficiary's access to care.

(c) Eliminating hospital requirement for coverage of extended care services.—Under current law services in a skilled nursing facility are covered under Medicare only after an individual has been transferred to the facility from a hospital in which the individual was a patient for not less than three consecutive calendar days before being discharged in connection with the transfer.

The Commission believes the three day prior hospitalization rule has created a barrier to needed skilled nursing care for those who do not require hospitalization. Given that an increasing number of surgical procedures are performed on an outpatient basis, it is the Committee's belief that Medicare beneficiaries who require skilled nursing care should be entitled to such care in a skilled nursing facility when they do not need to be hospitalized and otherwise qualify for the home health benefit. The Congress has already eliminated the three day prior hospitalization rule for the home health benefit.

Explanation of provision

(a) Coinsurance rate of 20 percent of national average per diem for services furnished during first 7 days of each calendar year.—A Medicare beneficiary would be required to pay coinsurance amounts for the first 7 eays of covered services in a calendar year. The coinsurance amount for each day would equal 20 percent of the national average per diem Medicare reasonable cost for SNF services in the succeeding calendar year, as estimated by the Secretary each year. The Secretary would, in September of each year (beginning in 1987) promulgate the coinsurance amount which shall apply to post-hospital extended care services furnished in the succeeding year.

(b) Extension to 150 days in each calendar year.—The Medicare program would cover up to 150 days of post-hospital extended care services furnished during a calendar year.

(c) Eliminating hospital requirement for coverage of extended care services.—The three day prior hospitalization requirement to receive extended care services in a skilled nursing facility would be eliminated.

Effective date

(a) and (b) The coinsurance and extension of days would be effective for services furnished on or after January 1, 1988.

(c) The elimination of the three day hospital requirement would become effective for skilled nursing facility stays beginning on or after January 1, 1989.

Sec. 103. *Hospice care*

Present law

(a) Extension of coverage period—Under current law, a beneficiary who is terminally ill is entitled to elect to receive hospice care for periods of 90 days and one subsequent period of 30 days for a total of 210 of hospice care.

In keeping with efforts to cover catastrophic acute care medical costs, the Committee believes the hospice benefit should continue to be available to Medicare beneficiaries who are still terminally ill after the 210 day hospice benefit expires.

(b) Continued Certification of Terminal Illness for Extended Benefits.—Under current law in order to receive the hospice benefit the beneficiary's attending physician and the medical director (or staff physician) of the hospice program must certify, not later than two days after hospice care is initiated, that the beneficiary is terminally ill (i.e. that the beneficiary has a medical prognosis that his life expectancy is six months or less). If the beneficiary elects to receive hospice care for a second or third period, the medical director must recertify at the beginning of that period that the beneficiary is terminally ill.

Currently, some hospices are refusing to provide the hospice benefit to Medicare beneficiaries if they believe the individual will live beyond the 210 day limit because the hospice will not be reimbursed for care delivered beyond the 210 day limit.

Explanation of provision

(a) Extension of coverage period.—A Medicare beneficiary would be entitled to a subsequent extension of the hospice benefit after the 210 day limit under certain circumstances.

(b) Continued certification of terminal illness for extended benefits.—A subsequent extension period for the hospice benefit would be granted beyond the 210 day limit if the Medicare beneficiary was recertified as terminally ill by the attending physician or medical director.

Effective date

(a) and (b) The changes in the hospice benefit would be effective for hospice care furnished on or after January 1, 1988.

Sec. 104. *Blood deductible*

Present law

Under current law a beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) received by a beneficiary as part of the services furnished under the hospital insurance (Part A) program during each "spell of illness." There is also a separate deductible under Part B of Medicare equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary during a calendar year.

In keeping with the elimination of the "spell of illness" concept for hospital services, it is necessary to conform the blood deductible rules and eliminate the "spell of illness" concept for the blood deductible.

Explanation of provision

A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year, except that the deductible for such blood would be reduce appropriately, in accordance with regulations developed by the Secretary of Health and Human Servcies, to the extent that there had been a replacement of such blood. The Secretary is directed to utilize the same replacement requirements that are currently used for the Part B blood deductible replacement requirements.

A Medicare beneficiary would be required to pay only one blood deductible in a calendar year under Parts A or B in any calendar year.

Effective date

The changes in the blood deductible would be effective for blood or packed red blood cells furnished on or after January 1, 1988.

Sec. 105. Home health benefits

Present law

Under current law home health care is a covered benefit under both Medicare Parts A and B. Payment for home health care, however, is made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1 percent of home health is reimbursed under Part B.

Eligibility and reimbursement policies are identical for home health services reimbursed under Parts A and B. There is no coinsurance or deductible payment requirement for home health either under Part A or Part B.

Under current law, the Part B premium is set at 25 percent of total Part B program costs. Beginning in 1989, the Part B premium will be set at the lower of: (1) an amount sufficient to cover one-half of the costs of the program, or (2) the current premium amount increased by the percentage by which cash benefits were

increased under the Social Security cost of living adjustment (COLA).

Traditionally, Medicare Part A has been reimbursed from the Hospital Insurance Trust Fund which is financed almost exclusively from payroll taxes. It is the belief of the Committee that in order to help maintain the solvency of the Hospital Insurance Trust Fund that the home health benefit be transferred to the Part B portion of the Medicare program.

Explanation of provision

Beginning with fiscal year 1989, home health care would no longer be a covered benefit under Medicare Part A, except for individuals eligible for benefits under Part A who have not enrolled under Part B. Individuals eligible for benefits under Part A who have not enrolled under Part B would continue to be eligible for home health benefits under Part A. Individuals enrolled under Part B would only be entitled to receive home health benefits under Part B.

There would be no change in coverage or reimbursement policies for home health services. There also would be no change in current law regarding calculation of the Part B premium: the 1989 premium would be based on the 1988 premium increased by the Social Security COLA.

Effective date

Effective for home health services furnished on and after January 1, 1989.

Sec. 106. Supplemental premium

Present law

Under current law, individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement cash benefits are eligible, without additional application, to coverage under the Hospital Insurance (Part A) program of Medicare without any payment for the coverage. Eligibility for Part A coverage begins with the first day of the month in which an individual eligible for retirement benefits as a social security retirement beneficiary, qualified railroad retirement beneficiary, or "survivor" beneficiary under either program attains age 65. Entitlement ends with the earlier of the last day of the month of death or the last day of the month before the month in which the beneficiary no longer meets the requirements for entitlement to social security, railroad retirement, or survivor benefits.

Part A coverage also is available, without payment of the Part A premium, to individuals under age 65 who have been entitled for not less than 24 months to social security or railroad retirement benefits on the basis of disability. This entitlement for Part A coverage applies to qualified railroad retirement disability beneficiaries and the following categories of social security beneficiaries: disabled workers, disabled widows and widowers between the ages of 50 and 65, certain women age 50 or older entitled to mother's benefits, and individuals age 18 and over who receive social security benefits because they became disabled before reaching age 22.

Entitlement to Part A begins with the first day of the 25th month of entitlement to social security or railroad retirement benefits on the basis of disability. Such entitlement to Part A continues until the end of the month following the month in which notice of the termination of disability status is mailed to the beneficiary, or, if earlier, with the end of the month before the month in which the beneficiary attains age 65.

Further, Part A coverage is available, without payment of the Part A premium, to individuals, even though they have not reached age 65, who have end-stage renal disease (i.e., kidney impairment that appears irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life). End-stage renal disease Medicare benefits are available only after an application for Medicare benefits is filed.

The bill substantially improves Medicare benefits by adding catastrophic coverage. In developing a funding mechanism for such improvements, the Committee followed four basic principles. First, the funding mechanism should cover the cost of the benefit improvements. Second, the committee believed that the cost of the benefit improvements should be borne by those receiving the improved benefits. Third, the burden of the additional cost largely should be based on the ability to pay, since there is already in place a $17.90 per month Part B premium that is scheduled to increase substantially under present law. This protects low-income beneficiaries from having to pay a substantial share of the new costs. Fourth, the committee did not want to require the filing of a tax return by any individual not otherwise required to file a return.

The Committee examined various alternatives in light of these principles and determined that an income-related supplemental premium paid by Medicare enrollees and collected through the income tax system was the fairest and most administrable method of financing the bulk of the new catastrophic benefits. In addition, because the Committee believed that a small portion of the cost of the new benefits should be borne equally by all Part B enrollees, the bill would provide that Part B enrollees would pay an additional $1 per month Part B premium beginning in 1990 and an additional $.40 per month beginning in 1991.

Under the bill, the supplemental premium would be collected only from those required to file tax returns and thus will affect less than half of all Medicare beneficiaries. Unlike the existing Part B premium, which is the same for all Part B enrollees regardless of income, the supplemental premium would increase according to the enrollee's adjusted gross income ("AGI").

The supplemental premium would be mandatory for individuals eligible to receive Part A coverage in order to avoid the adverse selection problem (i.e., withdrawal by the healthier part of the population) that could occur if a substantial premium were imposed on a voluntary basis. The effect of adverse selection could be to increase the per enrollee cost of Medicare and thus require that the supplemental premium be raised to retain budget neutrality.

The Committee decided that the supplemental premium should be less than the portion of the value of the Medicare coverage received that is not paid for by the basic premium or employee pay-

roll taxes. Therefore, the maximum supplemental premium was set at 33 percent of the portion of Medicare coverage not paid for the the beneficiary (i.e., 50 percent of Part A coverage and the excess of the value of Part B coverage over the Part B premium).

Explanation of provision

In general, under the bill, an individual (other than certain individuals described below) who is eligible in any year for Medicare Part A coverage by reason of eligibility for social security, railroad retirement, disability, or end-stage renal disease benefits, and who is not required to pay the Part A premium, would be required to pay a supplemental premium based on the individual's AGI for that year.[1] This premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI. The premium would be paid and collected in the same manner as an income tax.

Amount of the premium

Under the bill, the amount of the premium imposed on any medicare-eligible individual would be determined for taxable years beginning in 1988 under the following table:

If the adjusted gross income for the taxable year is:		The annual premium per Medicare-eligible individual is:
Over	But not over	
$0	$6,000	$0
$6,000	$6,143	$10
$6,143	$6,287	$20
$6,287	$6,430	$30
$6,430	$6,573	$40
$6,573	$6,716	$50
$6,716	$6,860	$60
$6,860	$7,003	$70
$7,003	$7,146	$80
$7,146	$7,289	$90
$7,289	$7,433	$100
$7,433	$7,576	$110
$7,576	$7,719	$120
$7,719	$7,862	$130
$7,862	$8,006	$140
$8,006	$8,149	$150
$8,149	$8,292	$160
$8,292	$8,436	$170
$8,436	$8,579	$180
$8,579	$8,722	$190
$8,722	$8,865	$200
$8,865	$9,009	$210
$9,009	$9,152	$220
$9,152	$9,295	$230
$9,295	$9,438	$240
$9,438	$9,582	$250
$9,582	$9,725	$260
$9,725	$9,868	$270
$9,868	$10,011	$280

[1] In addition, enrollees in Part B are required to pay an additional $1 per month Part B premium beginning in 1990 and an additional $.40 per month beginning in 1991. (See sec. 206 of the bill.) These additional premiums are to be indexed in the same manner in which the Part B premium is currently indexed.

If the adjusted gross income for the taxable year is:		The annual premium per Medicare-eligible individual is:
Over	But not over	
$10,011	$10,155	$290
$10,155	$10,298	$300
$10,298	$10,441	$310
$10,441	$10,585	$320
$10,585	$10,728	$330
$10,728	$10,871	$340
$10,871	$11,014	$350
$11,014	$11,158	$360
$11,158	$11,301	$370
$11,301	$11,444	$380
$11,444	$11,587	$390
$11,587	$11,731	$400
$11,731	$11,874	$410
$11,874	$12,017	$420
$12,017	$12,160	$430
$12,160	$12,304	$440
$12,304	$12,447	$450
$12,447	$12,590	$460
$12,590	$12,734	$470
$12,734	$12,877	$480
$12,877	$13,020	$490
$13,020	$13,163	$500
$13,163	$13,307	$510
$13,307	$13,450	$520
$13,450	$13,593	$530
$13,593	$13,736	$540
$13,736	$13,880	$550
$13,880	$14,023	$560
$14,023	$14,166	$570
$14,166		$580

The annual premium determined under the above table would be pro-rated based on the number of months an individual is a medicare-eligible individual during the taxable year. The same proration rule is to apply in the case of a short taxable year, except that in such case, the individual's adjusted gross income would be annualized (assuming that the individual would have received adjusted gross income at the same rate for a full 12 months).

Special rule for joint returns

In the case of a joint return, the premium table would be applied separately to each spouse who is a medicare-eligible individual. For this purpose, the AGI of each spouse would be deemed to be one-half of the couple's combined AGI under the joint return.

Adjustment of the premium table for years after 1988

By December 15 of 1988, and of each subsequent calendar year, the Secretary would prescribe an adjusted table applicable to taxable years beginning in the immediately succeeding calendar year. The Secretary would adjust the premium amounts by the medicare inflation factor. Each other dollar amount would be adjusted by the cost-of-living adjustment applicable to such year for purposes of the income tax brackets (sec. 1(f)(3) of the Code). Adjustments of amounts in the table would be rounded to the nearest dollar.

The medicare inflation factor for any calendar year would be the percentage (if any) by which the medicare value for such year exceeds the medicare value for 1988. The medicare value for any year is the sum for January of such year of (1) 50 percent of the value of Part A coverage (i.e., the monthly actuarial rate established under sec. 1818(d)(1) of the Social Security Act), and (2) the excess of (a) the value of Part B coverage (i.e., twice the monthly actuarial rate established under sec. 1839(a)(1) of the Social Security Act) over (b) the monthly premium paid for such coverage.[2] For purposes of determining the premium paid for Part B coverage, the following would be disregarded: (1) any penalty premium charged to individuals who are not continuously enrolled in Part B throughout the period they are entitled to enroll in Part B (sec. 1839(b) of the Social Security Act); (2) the extra Part B premium payable by residents of a U.S. possession and by individuals who are enrolled in Part B but not Part A (sec. 1839(e)(4) and (5) of the Social Security Act discussed below); and (3) the special ceiling on premiums limiting any premium increase to the increase in an individual's social security benefit (sec. 1839(f) of the Social Security Act).

Medicare-eligible individual

In general.—Generally, an individual would be a medicare-eligible individual with respect to a month if such individual is entitled to (or, on application, with no payment, would be entitled to) Part A coverage for such month. An individual, other than a nonresident alien, would be treated as a medicare-eligible individual for the month in which he attained age 65 and any subsequent month unless such individual established to the satisfaction of the Secretary that he was not a medicare-eligible individual for such month.

Exceptions.—An individual would not be a medicare-eligible indivdual for any month for which he was (1) entitled to benefits solely because he paid a Part A premium; (2) a resident of a U.S. prossession who paid the extra Part B premium applicable only to such residents (sec. 1839(e)(4) of the Social Security Act); or (3) a qualified nonresident.

A qualified nonresident would be an individual (1) who had received no medical services during the current and four preceding taxable years for which payment was or would be made under Medicare Part A; (2) who was not entitled to Medicare Part B benefits at any time during the current and four preceding taxable years; and (3) who had been present in a foreign country or countries for at least 330 full days during the 12-month period ending at the close of the current taxable year and each of the four consecutive preceding 12-month periods. In the year of death, the 330 day test would be satisfied if the decedent spent more than 90 percent of the days preceding the death in a foreign country or countries.

The exemption for Part A enrollees who pay the Part A premium was based on the fact that such enrollees already paid for the full cost of Part A coverage. The residents of United States possessions were excepted because they paid an additional Part B premium for the new catastrophic benefits. Qualified nonresidents were

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[2] Under the Social Security Act, the monthly actuarial rates for Part A and Part B coverage are estabished prior to December 15 of the preceding year.

viewed as, in effect, not receiving coverage under Part A and thus were exempt from the supplemental premium.

Treatment as a tax

For purposes of the rules regarding payment (including estimated payments) and collection of taxes (Subtitle F), the supplemental premium would be considered an income tax. In addition, the supplemental premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI.

It would not however, be considered an income tax for purposes of determining either the amount of any credits allowable against income tax or the alternative minimum tax (sec. 55). Section 15, relating to changes in tax rates, would not apply to the supplemental premium.

Information reporting

The bill would require the Secretary of Health and Human Services to make an information return stating (1) the name, address, and taxpayer identification number of each individual who is entitled to Part A coverage without payment for any month during the calendar year (other than an individual who is: (a) entitled to Medicare Part A solely by reason of the payment of a Part A premium; on (b) resident of a U.S. possession who pays the extra Part B premium applicable only to such residents (sec. 1839 (e)(4)), and (2) the number of months such taxpayer is so entitled.

Effective date

The supplemental premium provision of the bill would be effective for taxable years beginning after December 31, 1987.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

Sec. 201. Limitation on Medicare out-of-pocket expenses under Part B

Present law

(a) Limitation on Medicare out-of-pocket expenses under part B.—Under current law any Medicare beneficiary who is entitled to Medicare Hospital Insurance (Part A) benefits is automatically enrolled and covered for Supplementary Medical Insurance benefits (Part B), unless the person indicates he does not want to be covered for such benefits. Those not entitled to Medicare Hospital Insurance benefits may voluntarily elect to enroll in the Supplementary Medical Insurance program.

In general, the Supplementary Medical Insurance benefits program is financed through premium payments by enrollees ($17.90 a month in 1987), together with contributions from general revenue funds appropriated by the Federal government, and certain deductible ($75 in 1987) and cost-sharing (coinsurance) provisions.

The Supplementary Medical Insurance benefits program pays for certain physician services, and other outpatient services including X-Ray, laboratory tests, durable medical equipment, prosthetic devices, and certain therapies.

Under current law, there are certain cost sharing requirements. Before Medicare makes any payment for covered expenses during any calendar year, the individual must meet an annual deductible of $75. The deductible must be made up of "covered" expenses—that is, expenses which would, except for the deductible, constitute incurred expenses with respect to which benefits are otherwise payable.

Medicare beneficiaries must pay coinsurance amounts for covered Part B services under current law. Services by a physician or supplier of services under the Supplementary Medical Insurance program are generally reimbursed under Medicare on a "reasonable charge" basis. Medicare reimburses 80 percent of covered "reasonable charges" (or in some cases, the "reasonable costs") and beneficiaries are responsible for the remaining 20 percent in coinsurance payments. Beneficiaries are also responsible for any amount above the "reasonable charge" or "reasonable cost" determination.

Payment of a Part B blood deductible is also required under current law. A beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary in an outpatient setting during a calendar year. However, if the beneficary arranges for the replacement on a pint-for-pint basis, the beneficiary may not be charged the deductible.

The Committee believes that out-of-pocket costs for Part B services have become an increasing burden to Medicare beneficiaries. The General Accounting Office (GAO), in a recent report entitled "Medicare and Medicaid Effects of Recent Legislation on Program and Beneficiary Costs," found that beneficiary out-of-pocket cost per capita for Part B services increased from $395 in 1980 to $516 in 1985, about a thirty-one percent increase.

(b) Limitation on charges where catastrophic limit is reached.—Under current law institutional providers of services with agreements with the Medicare program may charge Medicare beneficiaries coinsurance amounts under the Part B program.

The Committee believes it must ensure that institutional providers (i.e., hospitals) not charge Medicare beneficiaries coinsurance once the beneficiary has reached the Part B catastrophic limit, whereby, Medicare would pay 100 percent of the reasonable charge, or in some cases, the reasonable cost allowed.

Explanation of provision

(a) Limitation on Medicare out-of-pocket expenses under part B.—After a Medicare beneficiary has incurred out-of-pocket Part B covered expenses in a calendar year which exceeded the Part B catastrophic limit: (1) Medicare would pay 100 percent of reasonable charges (or in some cases, the reasonable costs) for any additional Part B covered services in the year, and (2) no further deductibles would be required. Amounts above the full Medicare level paid to physicians who did not accept assignment would not be included in the catastrophic limit.

Out-of-pocket Part B expenses would be defined to include the Part B $75 deductible, the Part B blood deductible, the 20 percent coinsurance required to be paid by beneficiaries for Part B benefits and $250 of reimbursable outpatient mental health services.

The Part B catastrophic limit would be $1,043 in 1989. For succeeding years, the limit would equal the limit for the preceding year, increased by the cost-of-living adjustment to Social Security benefits. Because of the need to ensure that the overall catastrophic proposal is budget neutral, the Part B limit will not become effective until January, 1989, and is therefore, $1,000 plus the projected cost-of-living adjustment, or $1,043, for that year.

For prepaid health care organizations paid on the basis of aggregate reasonable cost, the Secretary would be required to provide for an appropriate adjustment to their payment amounts to reflect the increase in protection as if payment were made on an individual-by-individual basis.

(b) Limitation on charges where catastrophic limit is reached.—Institutional providers of services with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider.

Effective date

The limitation on out-of-pocket expenses would be effective for services provided on or after January 1, 1989.

Sec. 202. Extending home health services

Present law

Under current law home health services are covered under Medicare if: (1) the services are ordered by and included in the plan of treatment established by a physician; (2) the services are required on an intermittent basis; (3) the services are performed by or under the direct supervision of a licensed nurse; and (4) the services are reasonable and necessary for the treatment of an illness or injury.

To meet the requirement for intermittent skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. Current guidelines generally define intermittent as permitting daily skilled nursing visits for up to eight hours a day for up to two to three weeks if medically reasonable and necessary. Daily is defined as five days per week.

The Committee believes that the intermittent rule has created an unnecessary barrier to receiving home health services. The Committee believes that daily care should be available on the weekends as well as during the week and that allowing for only three weeks of continuous care in a given period does not meet the needs of many Medicare beneficiaries.

Explanation of provision

The intermittent skilled nursing care definition for home health services would be expanded so that "daily" would be defined as seven days per week and care would be provided for up to 35 days in a given period. A beneficiary could receive more than 35 days of consecutive home health services if the physician certified that the beneficiary required a subsequent period based on certification of exceptional circumstances requiring such services.

All other Medicare home health requirements would continue to apply. All that would be changed would be the definition of daily to

mean seven days a week and that the intermittent rule would not become operative until a Medicare beneficiary required daily care under this new definition. In these cases, a Medicare beneficiary could only receive care for up to 35 consecutive days in a given period, except by physician certification of exceptional circumstances.

Effective date

The change in the intermittent care rule would be effective for services furnished on or after January 1, 1989.

Sec. 203. Increase in maximum payment allowed for outpatient mental health services

Present law

Under current law the maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personality disorder is $250 per calendar year for each Medicare beneficiary. Medicare only recognizes a maximum of 62.5 percent of $500 of charges, or $312.50, and will reimburse 80 percent of this amount or $250. Consequently, the effective coinsurance rate is 50 percent for the first $500 of outpatient mental health services.

The amount of Medicare reimburseable mental health services has not changed since the Medicare program was instituted in 1965. The Subcommittee believes that the $250 limit for mental health services has not kept pace with inflation and should be raised in order to provide a reasonable mental health benefit. If the $250 limit had been adjusted for inflation, it is estimated that the benefit would now be worth over $2,000. Increasing the outpatient benefit should reduce the current incentive for hospitalizing those with mental disorders.

Explanation of provisions

The current law maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personality disorders would be raised to $1,000 per calendar year for each Medicare beneficiary. The coinsurance requirement would remain the same. Thus, Medicare would recognize up to 6.5 percent of $2,000 of charges or $1,250, and would reimburse 80 percent of this amount or $1,000. Amounts in excess of current reimburseable limits ($250) would not be counted towards the Part B catastrophic limit.

The $1,000 reimbursement limitation per calendar year applies only to expenses incurred for physicians' services and any items or supplies furnished by the physician in his office in connection with the treatment for a mental, psychoneurotic or personality disorder.

As under current law, services by other health personnel, including home health services, outpatient hospital services and services furnished in a community mental health center, would not be subject to the special psychiatric limitation even though the services are in connection with a condition included in the definition of "mental, psychoneurotic and personality disorder." Further, as under current law, the services of auxiliary personnel who are ren-

dering services "incident to" the physician's professional service would not be included in the $1,000 reimbursement limitation.

Effective date

The expanded outpatient mental health benefit would become effective for services provided on or after January 1, 1989.

Sec. 204. Mailing of notice of Medicare benefits and participating physician directories

Present law

Under current law the Social Security Administration annually publishes a "Medicare Handbook," which expalins Medicare coverage and describes in general what Medicare does not cover. The Social Security Administration also publishes annually directories by geographic area of physicians who participate in the Medicare program. Under the Omnibus Reconciliation Act of 1986, these directories are to be made available in Social Security officers and hospitals, and a notice explaining that the directories are free upon request is to be included with the Soecial Security check mailed to beneficiaries in April.

The Committee believes that the passage of Medicare catastrophic legislation will result in some uncertainty on the part of Medicare beneficiaries about what the new benefits do and do not include. In is also the belief of the Committee that the method by which the participating physician directories are currently distributed is too cumbersome a process.

Explanation of provision

The Secretary would be required to distribute annually a notice to all Medicare beneficiaries (whether they receive benefits under Part A or B) which would provide a simple, clear explanation of Medicare benefits and the health care services from which benefits are not available. This notice would also include a general explanation of the limits of the Medicare and Medicaid programs with regard to long term care benefits.

In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January, 1988 by Medicare carriers. Directories would be organized regionally to facilitate their use by beneficiaries. One or more directories would be used in each carrier service area as appropriate. Physicians would be listed by specialty and locality.

Currently, funding for the distribution of the participating physician directories comes from the Medicare carriers' budgets. It is the expectation of the Committee that the Appropriation Committee will provide additional funding for the carriers' to cover the cost of mailing a directory to every Medicare beneficiary each year.

Effective date

The provision would first apply to annual notices and directories for 1988. The annual notice would be sent by January 31, 1988, or 3 months after the date of enactment of this legislation.

Sec. 205. Providing additional medical assistance for Indigent Medicare beneficiaries

Present law

Under current law, eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The income and resource eligibility criteria for the Medicaid differ substantially among the states. All state Medicaid plans, except for Wyoming, pay the monthly Medicare Part B premium payment for their dual eligible beneficiaries who are cash assistance SSI recipients under a "buy-in" agreement. If a state does not buy-in for Part B coverage on behalf of cash assistance beneficiaries, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there had been a buy-in arrangement. The Federal government does match state payments for copayments for cash assistance beneficiaries. States may pay the Medicare coinsurance (generally 20 percent of the "reasonable charge") and deductible amounts in full; States may also pay lesser amounts.

Public Law 99–509 created an optional categorically needy group composed of the elderly and disabled with incomes up to the Federal poverty level. A State choosing this option could pay all Medicare cost sharing for these individuals and if so, was also required to cover some newly eligible pregnant women and children. States are required to use the SSI resources standard or a higher resource standard in determining eligibility.

As a result of the catastrophic coverage provided by this legislation, States would pay a reduced amount for those individuals for whom they currently pay the Medicare deductibles and coinsurance. It is the belief of the Committee that the States should use these savings to improve benefits for the indigent elderly and disabled.

Currently, none of the States buy into the Medicare program for all of the elderly whose incomes are below the Federal Census Bureau poverty level, now $5,255 for single elderly individuals and $6,628 for a couple in 1987. The Congressional Budget Office, in 1986, estimates that about 3.3 million of the elderly had incomes below for Federal Poverty level, but only 1.1 million are covered under Medicaid. The 2.2 million individuals not now receiving Medicaid are also most likely to lack private Medigap insurance and least likely to be able to afford Medicare's cost sharing requirements.

Explanation of provisions

The Federal Supplemental Security Income (SSI) program would be amended to establish a separate category of elderly and disabled for whom state Medicaid programs, including states operating under Section 1115(a) waivers, would be required to pay the Medicare premium, deductibles and coinsurance amounts. Federal matching payments would be available for these expenses under the same formula states are currently reimbursed under the Medicaid program.

Although states are required to cover Medicare's cost sharing requirements under this proposal, States would be permitted to utilize the Section 1843 mechanism to implement their Medicare "buy-in" programs to cover Medicare eligible individuals.

All elderly and disabled with incomes up to the Federal Census Bureau poverty level (i.e. incomes up to $5,255 for an elderly individual and $6,628 for a couple in 1987) and who meet the resource standard would be entitled to participate in this program. States would be required to use the SSI resource standards, or a higher resource standard, in determining eligibility

This proposal would not require the States to make payment for regular Medicaid benefits.

Effective date

The States would be required to pay the (1) monthly premium for months beginning with July, 1988, and (2) items and services furnished on and after July 1, 1988.

Sec. 206. Adjustment in Medicare Part B premium

Present law

(a) Transitional Adjustments in 1990 and 1991.—Under current law premiums for Part B of Medicare are paid on a monthly basis according to an amount established in advance for each calendar year. The current method (effective for 1984–1988) of determining the monthly premium is to use a formula that sets the premium rate at 25 percent of the amount needed, in the aggregate, to cover program costs for aged beneficiaries. In the case of beneficiaries who have their premiums deducted from their Social Security checks, if there is a Social Security cost-of-living adjustment that is less than the amount for the increased premium, the premium increase otherwise applicable for 1987 or 1988 will be reduced to avoid a reduction in the beneficiaries' Social Security checks.

For calendar years beginning in 1989, the calculation of the Part B premium will return to prior law so that the premium rate will be the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

To assure that the total catastrophic proposal is revenue neutral for fiscal years 1988 through 1992, a small additional premium will be necessary in 1990, 1991, 1992.

(b) Part B premium for residents of U.S. Commonwealths and Territories.—Under current law all Medicare beneficiaries who voluntarily enroll in Part B of Medicare are subject to the same Part B premium payment rules and receive the same Medicare benefits, notwithstanding that they may reside in the American Commonwealths of Puerto Rico and Northern Mariana Islands or the Territories of Guam, the Virgin Islands, and America Samoa.

Concern has been expressed by some of the Commonwealths and Territories that if their residents, who are Medicare beneficiaries, are not required to share in the cost of the catastrophic benefits contained in this legislation, as are Medicare beneficiaries in the

States, then their Medicare beneficiaries will not be entitled to Medicare catastrophic benefits provided in this legislation.

It is the Committee's intention to finance all of the catastrophic benefits in 1988 and 1989 from a supplemental premium charged Medicare beneficiaries who file a Federal Income Tax Return. As each Commonwealth and Territory has its own internal revenue code that is not amended by Federal legislation and the residents of these U.S. possession are not subject to the Federal Internal Revenue Code unless they have U.S. source income, it is the Committee's belief that some alternative method of payment is necessary in order to require Medicare beneficiaries in the U.S. possessions to pay their fair share of the cost of the catastrophic benefits.

Because Medicare beneficiaries in the U.S. possessions are subject to payment of the Part B premium if they voluntarily enroll in Part B, the Committee believes that requiring an additional premium to the current Part B premium for these Medicare beneficiaries is the most equitable and administratively feasible method of collecting revenue to finance the catastrophic benefits in the U.S. possessions.

(c) Part B premium for individuals enrolled under part B but not entitled to benefits under part A.—Under current law individuals aged 65 and over who are not Social Security beneficiaries and therefore not entitled to Medicare Part A benefits may voluntarily elect to enroll in Medicare Part B. These individuals pay the same premium as is charged all other Medicare beneficiaries who enroll in Part B and are entitled to the same benefits as other Medicare Part B beneficiaries.

Because these individuals will not be subject to the Medicare supplemental premium collected through the Federal income tax code, it is the Committee's intent to charge these beneficiaries an additional premium which would be added to their Part B premium. In this manner, these beneficiaries will help finance the Part B catastrophic benefits.

Explanation of provision

(a) Transitional adjustments in 1990 and 1991.—The monthly Part B premium for each Medicare beneficiary voluntarily enrolled in Part B for each month in calendar year 1990 would be $1.00 greater than the amount otherwise determined under current law. For calendar year 1991 the monthly Part B premium would be 40 cents greater than the amount otherwise determined under current law following the $1.00 increase in 1990. The net effect, according to CBO estimates, would be to increase the Part B premium by approximately $1.50 a mounth in 1991 and 1992 above current law Part B monthly premium amounts. In later years, as in current law, the Part B premium would increase (1) by an amount sufficient to cover one-half of the costs of the program for the aged or (2) by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

(b) Part B premium for residents of U.S. Commonwealths and Territories.—In the case of a resident of the Commonwealths of Puerto Rico or Northern Mariana Islands of Territories of Guam, the Virgin Islands or America Samoa, of the United States who

voluntarily enrolls in Medicare Part B the monthly Part B premium otherwise determined for that Medicare beneficiary in 1988 or 1989 would be increased by an amount that would equal one twelfth of the product of the average per capital additional benefits contained in this legislation (and related administrative costs), as determined by the Secretary during September of the previous year and the ratio of (1) the per capita actuarial value of the benefits under Parts A and B for residents of the Commonwealth or Territory who are entitled to Medicare Parts A and B benefits, to (2) the per capita actuarial value of the benefits under Parts A and B for resident of the United States who are entitled to Medicare Part A and B benefits.

In 1990, the monthly Part B premium beneficiaries would pay would be the sum of: (1) the current law Part B premium in 1989, (2) the amount added in 1989 for residents in each Territory or Commonwealth and (3) would be increased by the percentage of an amount sufficient to cover one-half of the costs of the program for the aged or by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

For subsequent years the Part B monthly premium would be increasd by current law provisions.

The monthly Part B premium assessed Medicare beneficiaries in the Commonwealths and Territories would not include the additional premium amounts described in section (a) above as beneficiaries in the Commonwealths and Territories would be required to pay the value of the additional benefits through the additional premium assessed under this section.

(c) Part B Premium for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—The monthly Part B premium for Medicare beneficiaries entitled to benefits under Part B but not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under Part A, would be in 1989, (1) the monthly premium otherwise determined for the individual under current law, (2) and increased by an amount equal to one-twelfth of the average, per capita additional benefits (and related administrative costs) the Secretary estimates (during September of 1988) would be payable for the additional benefits contained in this legislation.

In 1990, the monthly Part B premium beneficiaries would pay would be the sum of: (1) the current law Part B premium in 1989, (2) plus the amount added in 1989 for the Part B buy-in only beneficiaries and (3) would be increased by the percentage of an amount sufficient to cover one-half or the costs of the program for the aged or by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

For subsequent years the part B monthly premium would be increased by current law provisions.

Effective date

(a) The provision would apply to monthly premiums for months beginning with January 1990. (b) The provision would apply to monthly premiums for months beginning with January 1988. (c)

The provision would apply to monthly premiums for months beginning with Januray 1989.

Sec. 207. Changes in certification of Medicare supplemental health insurance policies.

Present law

(a) Establishment of New Medigap Standards.—Under current law Medicare supplemental health insurance policies (Medigap policies) must meet minimum standards before companies can market them as Medigap policies. The Standards are contained in a model state program approved by the National Association of Insurance Commissioners (NAIC) on June 1, 1979, and incorporated in section 1882 of the Social Security Act. This section is commonly referred to as the "Baucus Amendment."

The standards contained in section 1882 require Medigap policies to: (1) cover all of the Medicare Part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 91st through 150th day lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits; (2) cover the Medicare Part B coinsurance, which may be subject to a $200 deductible and a maximum benefit of $5,000 per year; (3) cover the Part A and B blood deductibles; (4) not define preexisting conditions more restrictive than as a condition that was diagnosed or treated within 6 months before the effective date of the policy; (5) automatically change as Medicare's deductibles and coinsurance requirements change; (6) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund of any premium paid; (7) provide cancellation and termination clauses to be prominently displayed; and (8) at the time of sale, provide a buyer's guide explaining benefits and limitations of Medicare supplemental insurance.

In addition, loss ratio targets were established for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

There are Federal sanctions, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain the Secretary's certification, (2) posing as a Federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

(b) Required mailing of notice.—Under current law there is no requirement that Medicare supplemental health insurance companies send a notice to their policyholders explaining changes made by the Congress and how this affects the premium charged.

(c) Required submission of advertising.—Under current law there is no requirement that Medicare supplemental health insurance companies submit for review their advertising copy to State Insurance Commissioners.

(d) Transition for current policies.—Under current law, whoever knowingly sells a health insurance policy to an individual entitled to Medicare Part A or enrolled in Medicare Part B, with knowledge that such policy substantially duplicates health benefits under the Medicare program, is considered guilty of a felony and upon conviction may be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

The Committee believes that because the Federal Minimum Benefit Requirements for Medigap policies contained in the Baucus Amendment include benefits that are in the catastrophic proposal, there is a need to amend the Federal law and in particular to waive the Federal penalties for duplication of Medicare benefits for some period in order to give States the opportunity to change their minimum benefit requirements for Medigap policies.

In order to reduce the confusion about Medicare benefits once catastrophic legislation is enacted, the Committee believes that Medigap insurers should be required to inform their policyholders of the changes in Medicare benefits and submit their advertising to State Insurance Commissioners.

Explanation of provisions

(a) Recommendations for new standards.—The Secretary of Health and Human Services, taking into consideration the Medicare catastrophic legislation passed by the Congress and any recommendations developed by the National Association of Insurance Commissioners, would be required to report to the Congress within 150 days after enactment his recommendations for changes that should be made in the Federal requirements contained in Section 1882 of the Social Security Act for certification of Medicare Supplemental policies.

It is the sense of Committee that Congress would promptly act on such recommendations and provide for appropriate changes in the Federal standards, for whcih states would adjust their laws in a timely manner.

(b) Required mailing of notice.—Medicare Supplemental policies in effect on Janury 1, 1988, would be required, on a one time basis by January 31, 1988, to send a letter to their Medicare policyholders that explains the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the medigap policies and the cost of the medigap premium.

(c) Required submission of advertising.—Companies providing Medicare supplemental policies would be required to submit their advertising (whether through the written, radio or television medium) to each State Insurance Commissioner (or comparable officer identified by the Secretary) in which they do business for review as to whether their marketing practices comply with state law.

The Committee intends that advertising copy would be submitted for review but that the company could use the advertisement, whether written, by radio or television medium, without waiting for formal approval of the advertising copy.

The Committee further wishes to clarify that only the advertisement to be shown to consumers be submitted for review and not

financial or other records surrounding the advertisement copy be submitted to the State Insurance Commissioner or other body designated by the State.

(d) Transition for current policies.—The Federal penalties for noncompliance with the substantial duplication of health benefit requirements contained in Section 1882 of the Social Security Act for existing Medicare supplemental health insurance policies would be suspended for the period January 1, 1988, and ending on December 31, 1989. However, new policies issued as of January 1, 1988, would still be subject to the penalties of fines of not more than $25,000 or imprisonment for not more than 5 years, or both, after Medicare catastrophic legislation is enacted.

Sec. 208. Extension of social HMO demonstration projects

Present law

Under Sec. 2355 of the Deficit Reduction Act of 1984 the Secretary of Health and Human Services approved waivers to establish a project to demonstrate the concept of a social health maintenance organization. The four demonstration sites selected were: SCAN Health Plan, Inc. Long Beach, California; Kaiser Permanente Medicare Plus II, Portland Oregon; Seniors Plus, Minneapolis, Minnesota; and Elderplan, Inc., Brooklyn, New York. These sites are to provide for the integration of health and social services under the direct financial management of a provider of services. The Social HMOs are to enroll Medicare beneficiaries voluntarily in the HMO model and services are financed on a prepaid, capitated, at-risk basis. Operations began in the spring of 1985 and are scheduled to end in the fall of 1988.

Because the demonstration sites have had some difficulty in enrolling a sufficient number of Medicare beneficiaries and therefore have not had an adequate amount of time to properly study the concept of a social HMO, the Committee believes that the waivers for the four demonstration sites should be extended.

Explanation of provision

The Secretary of Health and Human Services would be directed to extend without interruption, through September 30, 1992, the waivers granted under Sec. 2355 of the Deficit Reduction Act of 1984 for the social HMO demonstration project under the same terms and conditions (other than duration of the project) established under Sec. 2355. The Social HMOs would be at full risk in the third year and succeeding years. An interim report to Congress would be due by December, 1988, and a final report to Congress on the project would be due not later than March 31, 1993.

Sec. 209. Study on comprehensive medical coverage under the Medicare Program

Present law

There is no study now being conducted on the cost of expanding the Medicare program to provide comprehensive medical services, including long term care, either under a capitation arrangement or by a fee for service method of payment.

Because of the strong interest on the part of several Members of Congress and other interested parties that Medicare be expanded to include services not now covered under the Medicare program, in particular long term care, the Committee believes that a study should be conducted to assess, the need for, and costs of, providing these services under the Medicare program.

Explanation of provision.

The General Accounting Office (GAO) would be requested to conduct a study to assess the need for, and cost of, the following services in the Medicare program for Medicare beneficiaries: (1) an annual preventive care visit which would include diagnostic procedures performed during annual physician examination, including (as medically appropriate by sex) a routine Papanicolaou test, blood test for cholesterol levels, colorectal exam, and a mammogram, (2) an annual vision examininations and the dispensing of prescription eyeglasses, (3) dental services, including an annual dental examination and cleaning, tooth extractions, simple restorations, services required for dentures, surgical preparation of endentulous ridges, periodontal therapy and endodontics, (4) biannual hearing threshold testing and hearing aids for those with a significant hearing loss, (5) comprehensive long-term care services (including adult day care services, intermediate care facility services, home and community based services, outpatient drug therapy, and respite care) provided on a case-managed basis in the environment of least restriction, where approved and regularly recertified by a geriatric assessment team, and (6) prescription drugs and biologicals.

The GAO would be directed to make separate determinations of the cost of each of the services described above on the basis of fee-for service reimburement and on the basis of a comprehensive captitation payment arrangement. Cost estimates would be determined for 1988 and the succeeding four years.

Effective data

The GAO would be required to report to the Congress on the results of the study not later than six months after the date of the enactment of this Act.

Sec. 210. Research on long-term care for Mediare beneficiaries

Present law

The Federal government has funded some research on the delivery and cost of long term care for the Medicare population for a number of years, but essential data is still lacking and there has been no effort to coordinate the findings from these earlier studies.

Knowing that a greater proportion of the American population will require long term care services in the coming decades, it is the belief of the Committee that there is insufficient data for the Committee to make informed decisions concerning the delivery and cost of providing long term care under the Medicare program.

Explanation of provision

The Secretary of Health and Human Services would be required to provide for a new progam of research on issues relating to the delivery and financing of long term care for Medicare beneficiaries.

There would be authorized to be appropriated, in equal parts from the Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5 million each fiscal year from 1988 through 1992 to carry out the new research projects.

The new research projects would be in addition to the current level of effort by the Health Care Financing Administration's Office of Research and Demonstrations, the National Center for Health Services Research, the National Institute on Aging, and the Office of the Assistant Secretary for Planning and Evaluation.

This new research would focus on issues of delivering and financing long term care and would include at least the following areas: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for Medicaid benefits for such care, (2) how the financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services, (3) how relatives of Medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services, (4) the quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services, and (5) the effectiveness of consumer protections in the States and at the Federal level which assure adequate access to long term care (other than in a nursing home) and protect the rights of Medicare beneficiaries.

III. Budget Effects of the Bill

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made: the Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below. This estimate indicates that the combined costs and revenues in the bill will not add to the budget deficit, but indeed reduce the deficit slightly. The revenue estimate from the Joint Committee on Taxation is also included below.

A summary of the direct spending and revenue impact of the bill is shown in the table below:

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Outlays (direct spending)	1,025	3,880	5,410	6,330	7,445
Revenues	1,421	5,018	5,888	6,641	7,550
Net impact upon deficit	−396	−1,138	−478	−311	−105

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee states that the letter from the Congressional Budget Office indicates that there is a change in budget authority and that there are no new or increased tax expenditures as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2470.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As ordered reported by the Committee on Ways and Means on May 19, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Direct spending/offsetting receipts:					
Section 101 provisions:					
Eliminating the limit on covered hospital days:					
Budget authority	−10	−30	−60	−90	−130
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15	−50	−95	−150	−210
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20	−60	−110	−160	−220
Outlays	395	530	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10	75	175	290	410
Changing the calculation of the part A premium:					
Budget authority	15	25	25	25	25
Outlays	15	25	25	25	25
Effect on turst fund from change in part A premium:					
Budget authority	−16	−27	−30	−30	−35
Outlays	0	0	0	0	0
Section 102 provisions:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10	−30	−55	−85	−120
Outlays	170	275	315	350	385
Eliminating the prior hospitalization requirement of coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Section 103 provisions:					
Eliminating the 210 day limit on hospice benefits:					
Budget authority	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	1	1	1	1
Section 104 provisions					
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	(1)	−1	−2	−5	−5
Outlays	5	8	10	10	11
Section 105 provisions:					
Transfering home health benefits to part B:					
Effect on part A:					
Budget authority	0	130	445	865	1,360
Outlays	0	−2,896	−4,440	−5,106	−5,867
Effect on part B:					
Budget authority	0	3,435	4,690	5,270	6,075
Outlays	0	2,896	4,440	5,106	5,867
Section 201 provisions:					
Benefits from the cap on part B copayments:					
Budget authority	0	2,445	3,760	4,480	5,330
Outlays	0	2,065	3,515	4,310	5,125
Section 202 provisions:					
Extending home health benefits to 35 consecutive days:					
Budget authority	0	180	255	285	330
Outlays	0	155	240	275	315
Section 203 provisions:					
Increasing limit on payments for outpatient mental health services to $1,000 a year:					
Budget authority	0	100	200	270	350
Outlays	0	85	185	255	335
Section 205 provisions:					
Requiring state Medicaid programs to buy-in all Medicare beneficiaries with incomes below the poverty line:					
Budget authority	40	225	275	325	360
Outlays	40	225	275	325	360
Section 206 provisions:					
Adjusting part B premium:					
Budget authority	−5	−60	−370	−610	−685
Outlays	−5	−60	−370	−610	−685
Spending under Medicaid:					
Effects of Medicare provisions on Federal Medicaid costs:					
Budget authority	−85	−330	−470	−560	−660
Outlays	−85	−330	−470	−560	−660
Total direct spending/offsetting receipts:					
Budget authority	−106	5,945	8,438	9,785	11,685
Outlays	1,025	3,880	5,410	6,330	7,445
Amounts subject to appropriations:					
Section 201 provisions:					
Administrative costs to implement copayment cap:					
Outlays	30	30	20	20	20
Section 204 provisions:					
Annual notice to enrollees of benefits under Medicare (half from HI; half from SMI):					
Outlays	4	4	4	4	4
Mailing directories of participating physicians to all enrollees:					
Outlays	25	25	25	25	25
Section 210 provisions:					
Providing research funding on long-term care (half from HI; half from SMI):					
Outlays	5	5	5	5	5
Total amounts subject to appropriations:					
Outlays	64	64	54	54	54

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Revenues:					
Section 106 provisions:					
Imposing an income-related supplemental premium: [1]					
Revenues	1,421	5,018	5,888	6,641	7,550
Total:					
Budget authority	−106	5,945	8,438	9,785	11,685
Outlays	1,089	3,994	5,464	6,384	7,499
Revenues	1,421	5,018	5,888	6,641	7,550
Change in deficit	−332	−1,074	−424	−257	−51

[1] Less than $0.5 million.

Note: Components may not sum to total due to rounding.

The effects of this bill fall within function 570 and function 550.

1. Estimates are from the Joint Committee on Taxation.

Basis of estimate

Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). The bill would change the HI copayment requirements, effective January 1, 1988, with the result that Medicare's reimbursement costs would increase. It would also change the way in which the HI premium is calculated, which would affect only those enrollees not already entitled to HI benefits through previous payroll tax contributions.

Part B of Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount. This bill would alter copayment requirements under Part B of Medicare by capping each enrollee's annual liability for copayments, first effective for calendar year 1989. It would also provide some expansion of mental health and home health benefits.

Over the five-year projection period, the additional benefits provided under this bill would be financed by increases in the SMI premium and by implementation of a new income-related premium collected through the income tax system.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this bill, reimbursements per enrollee would increase by an estimated 10.9 percent annually over the same period. About 85 percent of the additional benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 15 percent of estimated costs would be due to increased use of Medicare-covered services by enrollees. The utilization responses assumed in the estimate were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the provisions would take effect on January 1, 1988.

Direct spending/offsetting receipts

Section 101 provisions

Section 101 of the bill contains five provisions, discussed in turn below. The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days.—Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care. Only a fraction of a percent of enrollees (fewer than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs for Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days.—Under current law, enrollees pay one-fourth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees used coinsurance or reserve days each year, account-

ing for an estimated 2.3 million coinsurance days and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year.—Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital in a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains as hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Indexing the first-stay hospital deductible to the COLA.—Under current law, the first-day deductible is tied to increases in the index used to update payment rates under the prospective payment system. Under this bill, the deductible would instead be tied to increases in the (third-quarter) consumer price index (the Social Security COLA). This would slow the rate of growth in the deductible, because the update factor is projected to increase by 35 percent from 1987 to 1992, while the COLA will increase by only 23 percent over the same period. In 1988, the deductible would be $544 under current law, but would be $541 if indexed to the COLA instead. By 1992, the deductible would increase to $700 under current law, but would be only $641 if indexed to the COLA. The additional costs to Medicare of this provision (after implementing all of the inpatient copayment provisions discussed above, as well as the SNF copyment provision discussed below) would be $10 million in fiscal year 1988.

Changing the calculation of the Part A premium.—Under current law, the premium charged to HI enrollees who are not entitled to benefits through previous payroll tax contributions is based on the first-day deductible amount. Under this bill, the method of determining the premium would be changed so that it would reflect the actuarial value of HI benefits. This would reduce the projected monthly premium amount for 1988 from $236 to $155, affecting about 23,000 enrollees. The costs to Medicare from this provision in fiscal year 1988 would be about $15 million.

Section 102 provisions

Section 102 contains provisions relating to Medicare coverage of stays in skilled nursing facilities. They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year.—The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital de-

ductible amount ($68 per day in 1988) are charged each day for days 21–100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 20 percent of Medicare's national average reasonable cost for the first seven days of each SNF stay; enrollees' coinsurance costs would be $23.50 per day in 1988 for each of the first seven days of each SNF stay.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $170 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays.—This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage, effective January 1, 1989. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $40 million for fiscal year 1989, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Section 103 provisions

Section 103 of the bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospice benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small cost due to this provision, eqaual to about $0.4 million in fiscal year 1988.

Section 104 provisions

Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. Section 5 of the bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 then they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Section 105 provisions

This section of the bill would transfer the financing for home health benfits from the HI trust fund to the SMI trust fund for all Part B enrollees, effective January 1, 1987. Medicare beneficiaries who are not enrolled under Part B could continue to receive home

health benefits under Part A. This would generate not net outlays costs, but it would alter budget authority totals under the two trust funds.

Section 201 provisions

Under Section 201 of the bill, each SMI enrollee's liability for copayments under the program would be capped at $1,043 in 1989. In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the SMI copayment cap would be $1,185 in 1992.

About 8.4 percent (or 2.7 million) of SMI enrollees would be affected by the copayment cap in 1989. As a result, SMI benefit costs would increase by $2.1 billion in fiscal year 1989. By 1992, more than 10 percent of enrollees would be affected by the copayment cap, at a cost to Medicare of $5.1 billion during the first year.

Section 202 provisions

Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. This bill would increase the limit to 35 days, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision, which would be effective January 1, 1989, is $155 million for fiscal year 1989. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the increased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Section 203 provisions

Current law limits reimbursement for outpatient mental health services to $250 a year per enrollee. This bill would increase the limit to $1,000 a year, effective for calendar year 1989. The coinsurance rate on the additional benefits would remain at 50 percent, as under current law, and the additional copayments resulting from this provision would not count toward the SMI copayment cap described elsewhere in this bill. The estimate costs for this provision are $85 million in fiscal year 1989. The estimate is based on current use rates for the mental health benefit and projected increases in utilization due to the higher limit. The estimates of increased utilization were based on results of a demonstration study of a similar benefit expansion conducted by the Department of Health and Human Services.

Section 205 provisions

Currently, state Medicaid programs may choose whether or not to pay Medicare premium and copayment costs for all Medicare enrollees with incomes below the poverty level. This bill would require states to cover these costs, thereby affecting approximately 46 states that do not currently provide this Medicaid benefit to all poor Medicare enrollees, effective July 1, 1988. The estimated costs of this provision are $40 million in fiscal year 1988. The cost esti-

mate is based on counts from the Current Population Survey of poor Medicare enrollees who do not receive Medicaid benefits, and on Medicaid program data showing the current cost of the proposed benefits per Medicare-eligible Medicaid beneficiary.

Section 206 provisions

This section provides for several adjustments to the current-law SMI premium. For most SMI enrollees, the SMI premium would be increased by $1.00 a month in 1990, and by an additional $0.40 a month in 1991, on top of the automatic increases that would result under current law. (Under current law, beginning in 1989 SMI premium increases may not exceed the rate at which Social Security benefits are adjusted each year to offset cost-of-living increases, as measured by the change in the third-quarter Consumer Price Index. This is referred to as the COLA.)

Two groups are exempt from the ad hoc premium increases described above, however, and would be subject to a different set of provisions. For residents of Puerto Rico and the other territories, the current-law SMI premium would be increased in 1988 and 1989 by the full insurance value of the new Medicare HI and SMI benefits provided under this bill. For U.S. residents who are enrolled in Part B but who are not eligible for Part A benefits, the current-law SMI premium would be increased in 1989 by the insurance value of the new Medicare SMI benefits provided under this bill. Beginning in 1990 and for all subsequent years, the total premium paid in 1989 by both groups of these enrollees would be indexed to the COLA.

The net effect of thse premium provisions would to generate additional premium receipts of $5 million fiscal year 1988, growing to $685 million by fiscal year 1992.

Federal Medicaid savings

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for dually-eligible enrollees, partially offset by increased Medicaid costs for the higher SMI premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $85 million in fiscal year 1988.

Amounts subject to appropriations

Section 201 provisions

Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap proposed in this bill, comprehensive information about both deductible and coinsurance amounts paid under Part B would have to be complied across all Medicare carriers for each

SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Section 204 provisions

Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explantation of Medicare benefits, beginning with calendar year 1988. The funds would be taken equally from the HI and the SMI trust funds. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

In addition, the Department would be required to mail annually a directory of participating physicians to each SMI enrollee, beginning calendar year 1988. The costs of this provision are estimated to be $25 million a year, again based on previous experience by the Social Security and the Health Care Financing administrations.

Section 210 provisions

Section 210 authorizes an appropriation of $5 million annually for each year from 1988 through 1992, to conduct research on long term care services for Medicare enrollees. The funds would be taken equally from the HI and the SMI trust funds.

Revenues

Section 106 provisions

This section would impose an income-related, tax-based supplementary premium on all people eligible for benefits under Part A of Medicare, excluding nonresidents, effective January 1, 1988. For individuals who were eligible for only part of the year, this supplementary premium would be pro-rated for the part of year during which they were Medicare-eligible. The supplementary premium rates would be indexed to the rate of growth in the subsidy value of Medicare benefits. The Joint Tax Committee estimates that revenues from this income-related premium would total $1.4 billion in fiscal year 1988.

6. Estimated savings to State and local governments: This bill would have an effect on State and local government budgets, since States share in the financing of Medicaid—paying about 45 percent of outlays. CBO estimates the following effects:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects on State/local Medicaid costs	−70	−270	−385	−460	−540

7. Estimate comparison: None.

8. Previous CBO estimates: H.R. 1280 and H.R. 1281.

Estimate prepared by: Sandra Christensen, Hinda Ripps Chaikind, Holly Harvey, and Don Muse.

10. Estimated approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

IV. Other Matters Required To Be Discussed Under the Rules of the House

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made: the bill, H.R. 2470 was ordered favorably reported to the House of Representatives on May 19, 1987, by voice vote.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health.

The Subcommittee conducted a total of eight hearings on the legislation including six hearings on extending catastrophic coverage under the Medicare program (January 29, 1987; February 25, 1987; March 3, 1987; March 4, 1987, March 10, 1987; and March 30, 1987). The Subcommittee conducted a hearing March 31, 1987, on the feasibility of financing and delivery a long-term care benefit under the Medicare program and a hearing April 23, 1987, on extending coverage of prescription drugs under the Medicare program.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of Rule XI of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Committee on Government Operations with respect to the subject matter contained in the bill.

4. INFLATION IMPACT

In compliance with clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the report bill, the Committee believes that the bill has no measurable effect on health care prices or consumer prices generally as the bill is budget neutral in each of the five years for which cost estimates are available.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

* * * * * * *

TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * * * *

MEDICAL ASSISTANCE FOR POOR AGED, BLIND, AND DISABLED INDIVIDUALS

SEC. 1622. For purposes of title XIX of this Act in the case of a State (as such term is used for purposes of this title XVI) and for purposes of any State program of medical assistance operating under a waiver approved under section 1115(a), each individual—

(1) who, but for income and resources, would be an eligible individual and is not otherwise eligible for medical assistance under that title or program,

(2) who is entitled to hospital insurance benefits under part A of title XVIII (including entitlement by reason of an enrollment under section 1818),

(3) whose income (as determined under this title) does not exceed 100 percent of the weighted average poverty threshold (as calculated by the Bureau of the Census for the second previous calendar year) applicable, as the case may be, to a family unit of one person 65 years and over or to a two person family unit with a householder 65 years and over, and

(4) whose resources (as determined under this title) do not exceed the resource level described in section 1905(p)(1)(D), or, at a State's option, a resource level established by the State under section 1905(p)(2)(B),

shall, without regard to section 1902(f), be eligible for medical assistance to the same extent and under the same conditions as a qualified Medicare beneficiary (described in section 905(p)(1)) would be eligible for medical assistance under the plan under clause (VIII) of section 1902(a)(10), section 1902(n), and section 1916(b), if the State had elected the option described in section 1902(a)(10)(E). For purposes of section 1903(a)(1), these individuals shall be considered to be qualified Medicare beneficiaries. Coverage of individuals under this section shall not be considered, for purposes of section 1902(m)(3), to be coverage of individuals under section 1902(a)(10)(E).

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

NOTICE OF MEDICARE BENEFITS

Sec. 1804. (a) The Secretary shall distribute annually a notice containing—

(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

(2) a description of the limited benefits for long-term care services availble under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).

Part A—Hospital Insurance Benefits for the Aged and Disabled

description of program

Sec. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of [hospital, related post-hospital] *inpatient hospital services, extended care services* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

scope of benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on this behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1)] inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

(1) inpatient hospital services;

(2)[(A) post-hospital] extended care services for up to [100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services] *150 days during any calendar year;*

(3) *subject to subsection (f),* home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one], *a* subsequent period of 30 days, *and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

(b) Payment under this part for services furnished an individual [during a spell of illness may not (subject ot subsection (c))] *may not* be made for—

[inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

[(2) post-hospital] *(1)* extended care services furnished to him [during such spell after such services have been furnished to him for 100 days during such spell] *during a calendar year after such services have been furnished to the individual for 150 days during that year;* or

[(3)] *(2)* inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3).]

(c)(1) If an individual is an inpatient of a psychaiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

(2) The period described in this paragraph—

(A) begins on the first day of medicare entitlement, and

(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

(4) In this subsection:

(A) The term "first day of medicare entitlement" means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

(B) The term "inpatient mental health services" means—

(i) inpatient psychiatric hospital services, and

(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.

(d)(1) Payment under this part may be for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) * * *

(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period* the individual may revoke the election during the period, in which case—

(i) * * *

* * * * * * *

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and [post-hospital] extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

[(B) notwithstanding sections 1814, 1816(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.]

(f) Subsection (a)(3) shall only apply to home health services provided to an individual during a month in which the individual is not entitled to benefits under part B.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during [any spell of illness] *the first period of continuous hospitalization (as defined in subsection (b)(3)) that begins in a calendar year* shall be reduced by a deduction equal to the inpatient hospital deductible *for that calendar year* or, if less, the charges imposed with respect to such individual for such

services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be charges so imposed. [Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such service (and for this purpose, if the customary charages for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).]

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.]

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eight of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.]

(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 8th day) on which he is furnished such services during the year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).

* * * * * * *

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher mulitiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in the year.]

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(2) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the inpatient hospital deductible under the subsection for the succeeding year.

(3) In this section, the term "period of continuous hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ends on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospital) involved.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICE

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

(B) in the case of [post-hospital] extended care services, such services are or were required to be given because the indivudual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services];

* * * * * * *

(6) with respect to inpatient hospital services or [post-hospital] extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 186(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hosptial extended care services, as the case may be, are not medically necessary; except that, it such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing faciltiy, as the case may be received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period the individual is terminally ill[;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) * * *

* * * * * * * *

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to [60] *100* percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus [80] *100* percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on [two-thirds of] the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

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HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

Sec. 1818. (a) * * *

* * * * * * *

[(d)(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

[(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductible for that following calendar year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1.]

(d)(1) The Secretary shall, during September of each year (beginning with 1987), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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scope of benefits

Sec. 1832. (a) * * *

(b) For definitions of [“spell of illness”,] “medical and other health services”[,] and other terms used in this part, see section 1861.

payment of benefits

Sec. 1833. (a) * * *

* * * * * * *

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f)* only whichever of the following amounts is the smaller:

(1) [$312.50] *$1,250*, or

(2) 62½ percent of such expenses.

* * * * * * *

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b).] *(a), (b), and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b).] *(a), (b), and (f).*

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837, the monthly premium [determined under subsection (a) or (e)] *otherwise determined under this section (without regard to subsection (f))* shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) * * *

* * * * * * *

(3)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month—

(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a). Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).

(4)(A) Notwithstanding the provisions of subsection (a), in the case of an individual who is a resident of a commonwealth or territory during a month—

(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is 1/12th of the product of—

(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987; and

(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

(II) the per capita acturial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

(C) The amount described in this subparagraph for a month in—

(i) 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B) for months in 1989, increased by the premium percentage increase (as defined in subparagraph (E)(ii)) for 1990; or

(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premiun increase percentage for that succeeding year.

(D) If any amout determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragaraph:

(i) The term "commonwealth or territory" means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

(ii) The term "percentage premium increased", for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.

(5)(A) Notwithstanding the provisions of subsection (a), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph is $\frac{1}{12}$th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987.

(C) The amount described in this subparagraph for a month—

(i) in 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B), increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph the term "part B only individual" means, with respect to a premiun for a month, an individual who—

(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

(ii) is entitled to benefits under this part, and

(iii) is not entitled to (or, on application without payment of an addtional premium, would not be entitled to) benefits under part A.

[(f)(1) If no cost-of-living increase becomes effective under section 215(i) in December of 1985, 1986, or 1987, the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disrearding subsection (b)) of the individual for such December.

[(2) If paragraph (1) does not apply to the monthly premiums for 1986, 1987, or 1988, if an individual is entitled to monthly benefits

under section 202 or 223 for Nobember and for December in the preceding year, and if the monthly premium for that December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (b)) be the greater of—

[(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or

[(B) the monthly premium (disregarding subsection (b)) for that individual for that December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.]

(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied,

(B) "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(2) In this subsection, the term "out-of-pocket part B expenses" means—

(A) the deductions established under subsection (b), and

(B) the difference between the payment amount provided under this part and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the proceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

(A) The Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would be made with respect to enrollees in the organization if payment were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year.

(5) In applying paragraphs (1) and (2), the dollar amount specified in subsection (c)(1) shall be deemed to be $312.50.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC.1842(a) * * *

* * * * * * *

(h)(1) * * *

* * * * * * *

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area *and to each individual enrolled under this part and residing in that area* and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

* * * * * * *

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into a modifica-

tion of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

* * * * * * *

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

* * * * * * *

Part C—Miscellaneous Provisions

definitions of services, institutions, etc.

Sec. 1861. For purposes of this title—

[Spell of Illness

[(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

[(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

[(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.]

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, *and* paragraph (7) of this subsection [, and subsection (i) of this section] means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatient (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

[For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), [section 1814(f)(2), and subsection (i) of this section] *and section 1814(f)(2),* such term includes any institution which (i) meets the require-

ments of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatient diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not[, except for purposes of subsection (a)(2),] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christain Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meet the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

[Post-Hospital Extended Care Services

[(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual

shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

except that such term shall not [(other than for purposes of subsection (a)(2))] include any institution which is primarily for the care and treatment of mental diseases. [For purposes of subsection (9)(2) such term includes any institution which meets the requirements of paragraph (1) of this subsection.] The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physican for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physican, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and servies to such individual) established and periodically reviewed by a physician, which items and services are,

except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (other than drug and biologicals) and durable medical equipment, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an "intermittent" basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.*

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute [post-hospital] extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such

extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital] extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital] extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

* * * * * * *

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

* * * * * * *

[Post-Hospital] Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only [(except for purposes of subsection (a)(2))] with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a [spell of illness] *year* to have such services treated as [post-hospital] extended care services for purposes of such part; and payment under part A may not be made for [post-hospital] extended care services—

(A) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such [spell] *year,* or

(ii) such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for [post-hospital] extended care services furnished an individual during any [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount [equal to one-eighth of the inpatient hospital deductible for each day before the 31st day] *equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 8th day* on which he is furnished such services in such a facility during such [spell] *year* (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

[(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.]

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c)*(1)*, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or [post-hospital] extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be

made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for [post-hospital] extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *
(b)(1) * * *

* * * * * * *

(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a) * * *

* * * * * * *

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as [post-hospital] extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any

individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received [post-hospital] extended care services in like manner and to the same extent as if the services furnished to him had been [post-hospital] extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute [post-hospital] extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

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INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

Part I. Tax on individuals.

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Part VIII. Supplemental medicare premium.

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PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

Sec. 59B. Imposition of supplemental medicare premium.

SEC. 59B. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) Imposition of Premium.—In the case of a medicare-eligible individual, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a premium equal to the annual premium for such year determined under subsection (b).

(b) Determination of Amount.—For purposes of this section—

(1) In General.—Except as otherwise provided in this subsection—

If the adjusted gross income for the taxable year is:		*The annual premium for the taxable year is:*
Over:	*But not over:*	
$0	*$6,000*	*$0*
6,000	*6,143*	*10*
6,143	*6,287*	*20*
6,287	*6,430*	*30*
6,430	*6,573*	*40*
6,573	*6,716*	*50*
6,716	*6,860*	*60*
6,860	*7,003*	*70*
7,003	*7,146*	*80*
7,146	*7,289*	*90*
7,289	*7,433*	*100*
7,433	*7,576*	*110*
7,576	*7,719*	*120*
7,719	*7,862*	*130*
7,862	*8,006*	*140*
8,006	*8,149*	*150*
8,149	*8,292*	*160*
8,292	*8,436*	*170*
8,436	*8,579*	*180*
8,579	*8,722*	*190*
8,722	*8,865*	*200*
8,865	*9,009*	*210*
9,009	*9,152*	*220*
9,152	*9,295*	*230*
9,295	*9,438*	*240*
9,438	*9,582*	*250*
9,582	*9,725*	*260*
9,725	*9,868*	*270*
9,868	*10,011*	*280*
10,011	*10,155*	*290*
10,155	*10,298*	*300*
10,298	*10,441*	*310*
10,441	*10,585*	*320*
10,585	*10,728*	*330*
10,728	*10,871*	*340*
10,871	*11,014*	*350*
11,014	*11,158*	*360*
11,158	*11,301*	*370*
11,301	*11,444*	*380*
11,444	*11,587*	*390*
11,587	*11,731*	*400*
11,731	*11,874*	*410*
11,874	*12,017*	*420*
12,017	*12,160*	*430*
12,160	*12,304*	*440*
12,304	*12,447*	*450*
12,447	*12,590*	*460*
12,590	*12,734*	*470*
12,734	*12,877*	*480*
12,877	*13,020*	*490*
13,020	*13,163*	*500*
13,163	*13,307*	*510*
13,307	*13,450*	*520*
13,450	*13,593*	*530*
13,593	*13,736*	*540*
13,736	*13,880*	*550*
13,880	*14,023*	*560*
14,023	*14,166*	*570*
14,166		*580.*

(2) Special rule where individual not eligible for entire taxable year; short taxable years.—If an individual is not a medicare-eligible individual for each month during his taxable year, the annual premium determined under this subsection shall be an amount which bears the same ratio to the amount determined under paragraph (1) as—

(A) the number of months during the taxable year for which such individual is a medicare-eligible individual, bears to

(B) 12.

A similar rule shall apply in the case of a taxable year of less than 12 months; except that adjusted gross income for the taxable year shall be annualized.

(3) Special rule for joint returns.—In the case of a joint return—

(A) this section shall be applied separately with respect to each spouse, and

(B) the adjusted gross income of each spouse shall be ½ of their combined adjusted gross income.

(4) Adjustments to table.—

(A) In general.—Not later than December 15 of 1988 and each subsequent calendar year, the Secretary shall prescribe a table which shall apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in the succeeding calendar year.

(B) Method of prescribing table.—The table which, under subparagraph (A), is to apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in any calendar year shall be prescribed—

(i) by increasing each dollar amount setting forth the amount of the premium in such table by the medicare inflation factor for such calendar year, and

(ii) by increasing each other dollar amount in such table by the cost-of-living adjustment for such calendar year (as defined in section 1(f)(3)).

(C) Medicare inflation factor.—For purposes of subparagraph (B), the medicare inflation factor for any calendar year is the percentage (if any) by which—

(i) the medicare value for such calendar year, exceeds

(ii) the medicare value for 1988.

(D) Rounding.—If any increase determined under subparagraph (B) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

(c) Definitions and Special Rules.—

(1) Medicare-eligible individual.—For purposes of this section—

(A) In general.—Except as otherwise provided in this paragraph, the term "medicare-eligible individual" means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

(B) Exceptions.—The term "medicare-eligible individual" shall not include for any month—

(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act,

(ii) any individual who is required to pay a premium for such month increased or computed under paragraph (4) or (5) of section 1839(e) of the Social Security Act, or

(iii) any qualified nonresident.

(C) TREATMENT OF INDIVIDUALS WHO HAVE ATTAINED AGE 65.—An individual (other than a nonresident alien) who has attained age 65 shall be treated as a medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless such individual establishes to the satisfaction of the Secretary that he is not a medicare-eligible individual for the month concerned.

(2) MEDICARE VALUE.—

(A) IN GENERAL.—For purposes of this section, the term "medicare value" means, for any calendar year, the sum of the Medicare part A value for January of such calendar year and the Medicare part B value for January of such calender year.

(B) MEDICARE PART OF VALUE.—For purposes of subparagraph (A), the term "Medicare part A value" means, with respect to any month, an amount equal to 50 percent of the monthly actuarial rate promulgated under section 1818(d)(1) of the Social Security Act for such month.

(C) MEDICARE PART B VALUE.—for purposes of subparagraph (A), the term "Medicare part B value" means, with respect to any month, an amount equal to the excess of—

(i) the amount equal to twice the monthly actuarial rate established under section 1839(a)(1) of the Social Security Act for the calendar year which includes such month, over

(ii) the amount of the monthly premium for such month established under section 1839 of such Act (without regard to subsections (b), (e)(4), (e)(5), and (f) thereof).

(3) QUALIFIED NONRESIDENT.—

(A) IN GENERAL.—For purposes of paragraph (1), the term "qualified nonresident" means, with respect to any month during the taxable year, any individual if—

(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is or will be made under part A of title XVIII of the Social Security Act,

(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years; and

(iii) such individual is present in a foreign country or countries for at least 330 full days during—

(I) the 12-month period ending at the close of the taxable year, and

(II) each of the 4 consecutive preceding 12-month periods.

(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirements of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

(4) COORDINATION WITH OTHER PROVISIONS.—

(A) NOT TREATED AS MEDICAL EXPENSE.—The premium imposed by this section shall not be treated as an expense paid for medical care for purposes of section 213.

(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

(i) the amount of any credit allowable under this chapter, or

(ii) the amount of the minimum tax imposed by section 55.

(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the premium imposed by this section shall be treated as if it were a tax imposed by section 1.

(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the premium imposed by this section.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART II—INFORMATION RETURNS

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Subpart B—Information Concerning Transactions With Other Persons

Sec. 6041. Information at source.

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Sec. 6050O. Returns relating to individuals entitled to receive benefits under Medicare part A.

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SEC. 6050O. RETURNS RELATING TO INDIVIDUALS ENTITLED TO RECEIVE BENEFITS UNDER MEDICARE PART A.

The Secretary of Health and Human Services shall make a return (at such times and in such form as the Secretary may prescribe) setting forth the name, address, and TIN of each individual who is entitled to receive benefits (other than by reason of the payment of a premium referred to in clause (i) or (ii) of section 59B(c)(1)(B)) under part A of title XVIII of the Social Security Act for any month during the calendar year and the number of months in the calendar year for which the individual is so entitled.

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SECTION 2355 OF THE DEFICIT REDUCTION ACT OF 1984

WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2355. (a) * * *

(b) A project referred to in subsection (a) is a project—

(1) * * *

* * * * * * *

(5) under which all payors will share risk for no more than two years, with the organization being at full risk in the third year *and in succeeding years;*

* * * * * * *

(d)(1) The Secretary of Health and Human Service shall submit a preliminary report to the Congress on the status of the projects and waivers referred to in subsection (a) 45 days after the date of the enactment of this Act.

(2) The Secretary shall submit a [final] *interim* report to the Congress on the projects referred to in subsection (a) not later than 42 months after the date of the enactment of this Act.

VI. ADDITIONAL VIEWS

ADDITIONAL VIEWS OF THE HONORABLE BILL FRENZEL

When I first heard of the President's proposal to provide catastrophic health insurance as a part of Medicare, I thought it was a wonderful idea. I still do. However, subcommittee changes to the original concept have produced a bill that may not live up to the original promises.

As submitted by the President, the bill was tight and its financing was simple. The concept was reasonably clean. Young persons were not being forced to finance health care for their elders.

The Health subcommittee and the full Committee made a number of important changes. The most obvious ones were in financing. Instead of the flat across-the-broad premium, the finance plan included both an across-the-board premium (Part B premium adjustment of $1.00 in 1990 rising to $1.50 in 1992) and a mandatory supplemental premium ranging from $1.18 to $70.00 per month based on income.

Because of anxieties expressed in the full Committee the variable financing element was described as a supplemental premium rather than a taxable actuarial value. The concept of the "premium" is substantially similar to "the taxable actuarial value."

For me, the financing is not the biggest problem. Either a flat premium or a variable income-based fee is acceptable. Actually, I prefer the income-based approach as a first step toward means-testing the Medicare program.

The benefit section, however, poses some real risks. One fact from the subcommittee background materials pamphlet (pg. 67) illustrates the problem. In the five-year period covered by the CBO estimates, the President's benefit package would have cost about $13 billion. The subcommittee's proposal costs about twice as much, $24 billion.

That is the general dimension of the problem. However, the most frightening aspect of the bill is the cost/revenue relationship in the years beyond 1992. The Department of Health and Human Services says that costs will exceed revenues in the period after 1992. CBO, with its usual uselessness, says only that it has no estimates after 1992.

HHS estimates annual deficits of $10 billion by 2000, and $30 billion by 2005. If those figures are anywhere near right, the result will be a raid on the Medicare Trust Fund or unacceptable premiums for older Americans. Either alternative is enough to give any sober Congressman pause.

The bill fills a needed gap in Medicare policy. Something like it is needed. Clearly some sort of legislation is called for.

This bill has a long way to go. It would be premature to stop it now. But it is appropriate to raise questions now, and demand answers now, and seek ways to reduce what seem to be unacceptable risks.

BILL FRENZEL.

ADDITIONAL VIEWS OF THE HONORABLE BRIAN DONNELLY TO ACCOMPANY H.R. 2470

The Committee on Ways and Means deserves credit for its efforts in drafting this legislation, the first major expansion of the Medicare program since its enactment in 1965. Unfortunately, I can only provide reluctant support for this measure. It is may belief that the legislation promises more than it delivers, and I have great concerns over two areas which the legislation does not address.

NON-ASSIGNED CLAIMS UNDER MEDICARE

The legislation's noble intent is to limit beneficiary out-of-pocket expenses for Part B services to $1,043 per year. The reality, of course, is that the legislation does not limit beneficiary expenses to the extent that the beneficiary's physician does not accept assignment. Thus, beneficiaries in all but one state [1] still can and will face "catastrophic" medical expenses even after H.R. 2470 is fully implemented.

Realistically, there is no reason that physicians should be allowed to balance bill Medicare beneficiaries who have incurred $1,043 in Part B expenses. Physician reimbursement under Medicare is determined on the basis of actual, customary and prevailing charges: standards determined by the physicians themselves.

Unfortunately, the Committee defeated an amendment I offered which would have mandated that all Medicare claims be assigned once a beneficiary had exceeded the Part B cap of $1,043 established in the legislation. According to the Congressional Budget Office, my amendment would have saved beneficiaries $938 million in calendar year 1988, a number which clearly demonstrates how pervasive the problem of balance billing is.

I recognize that the entire issue of physician reimbursement under Medicare is extremely controversial, and the Committee on Ways and Means will be closely examining those issues later this year. I felt—and still feel—that the only way to rein in health care costs is to impose some type of assignment requirement on physicians, and I will continue to pursue this issue further.

LONG-TERM CARE

Another area where the Committee bill falls short in addressing the true needs of the elderly is in the area of long-term care. The true catastrophic expenses for senior citizens come from custodial nursing home care. Yet Medicare reimburses only a miniscule portion of the costs for this care: much to the shock of many Medicare

[1] Massachusetts has enacted legislation prohibiting physicians from "balance billing" their patients. The law, which was the subject of numerous constitutional challenges, was recently upheld by the First Circuit Court of Appeals.

beneficiaries. Very few private insurance companies offer such coverage.

In this bill, the Committee missed an important opportunity to address these concerns of the elderly. The longer we wait, the more acute the problem will become. Senior citizens, generally, face catastrophic medical expenses when they are forced to go into a nursing home, not when they are hospitalized. No amount of planning and foresight on their part can prepare them for the costs they face in a nursing home. Rather, beneficiaries "spend down" their life savings and force Medicaid to pay for their care. Certainly, we have the ability to deal with senior citizens in a more humane manner.

The Committee rejected a modest amendment I offered dealing with long-term care which would have expanded the enormously successful S/HMO concept pioneered by Brandeis University. Although the Committee did agree to reauthorize the four existing S/HMOs, I would have preferred to see much larger demonstration projects. Fortunately, the Committee did agree with me on the need for research into long-term care, and authorized $5 million for each of the next five years for this research.

In conclusion, it is with reluctance that I support H.R. 2470. I believe that the Committee could and should have gone further in the areas I have mentioned, and hope that these issues are addressed on the floor of the House or by the Senate.

Brian Donnelly.

VII. DISSENTING VIEWS OF THE HONORABLE BILL ARCHER, PHILIP M. CRANE, RICHARD T. SCHULZE, HAL DAUB, JUDD GREGG, AND HANK BROWN

The original goal of the Committee on Ways & Means regarding Medicare catastrophic protection legislation was a noble one: to protect the elderly from the threat of financial ruin resulting from a devastating and prolonged illness. The thousands of elderly individuals who face impoverishment as a result of high hospital and other medical costs are of great concern to many of us. We believe, however, that while the problem of catastrophic health expenses warrants a solution, the alternative reported by the Committee (H.R. 2470, "The Medicare Catastrophic Protection Act of 1987") jeopardizes the financial viability of the Medicare program itself.

We are genuinely disappointed at the lack of actuarial information available to the Committee about how this expansion of the Medicare program will strain the already troubled Medicare trust fund. Many of us are disappointed that the Committee reported bill remains silent on the more probable catastrophic costs faced by the elderly, those of long-term care, such as prolonged stays in nursing homes. Furthermore, a number of us are wary of any Medicare program expansion not containing adequate safeguards to prevent the type of over-utilization that might threaten the program's collapse. In addition, a number of us are deeply concerned that this new entitlement program will eliminate much of the retirement health insurance market. Further, the proposal does not seek ways to expand the private sector's involvement in insuring those elderly individuals who face an acute catastrophic illness against financial ruin.

When evaluating the Committee acute care proposal, one might do well to remember the guidelines set forth by the President for his intitiative on Catastrophic Illness Insurance for the elderly. These guidelines were enumerated in the press release issued immediately following his 1987 State of the Union Address. The guidelines are as follows:

> We must provide meaningful protection against out-of-pocket expenses that substantially threaten family savings;
>
> The importance of Medicare, Medicaid and Medigap should be maintained and we should not encourage excessive use of services;
>
> Any catastrophic illness coverage should be voluntary, not a new government entitlement; and
>
> The proposal must be fully budget-netural, without the explosive potential of program expansions.

Several of us had hoped that the Committee would follow these guidelines in the design of the Committee bills so as to create a constructive and positive solution to the problem posed to the Committee. But even a cursory glance at the summary of this bill

shows us that the Committee's expansion of the Medicare program meets very few, if any, of the President's guidelines. Many of us feel that a number of the provisions of the bills directly conflict with these guidelines.

When dealing with any type of modifications or expansion of the Medicare program, Congress must be keenly aware of the prediction in the 1987 report of the Medicare trustees that, under alternative II-B assumptions, the trust funds would be exhausted by the year 2002. Any expansion of the benefits offered by the Medicare program should be budget neutral in both the near and distant future. However, many of us are genuinely skeptical that the Committee has taken proper precautions to ensure that this new entitlement program, along with its many well-intended expansions of current Medicare benefits, will not create large deficits in future years. Should deficits occur, this program will only quicken the arrival of the impending Medicare financial crisis, thus threatening the future availability of the very core of benefits already offered under the Medicare program.

While few of us dispute that this bill does provide meaningful protection for out-of-pocket expenses, as called for in the first of the President's guidelines, several of us would like to point out that a number of the elderly might be misled to believe that all out-of-pocket costs of illness, whether for acute or long-term medical care, above the cap of approximately $1700, are covered. The title of the bill "The Medicare Catastrophic Protection Act of 1987," is certainly a misnomer. Even with the expanding the program, Medicare still does not cover many medical bills that can be substantial. For example, such costly expenses may include physician fees beyond Medicare-approved charges, dental care, prescription eyeglasses, and outpatient prescription drugs. More important, the bill does not address the issue of expenses for long-term care, which can be truly catastrophic and often represent the greatest fears for the elderly. Clearly, the bill is misleading, as it gives the elderly the impression that nursing home or other extended care services will now be covered by Medicare.

Several of us are also distressed to see that this bill seems to conflict directly with the President's guideline that the importance of medigap insurance be maintained. Instead of encouraging greater use of the private sector, the proposed Medicare catastrophic program replaces, and would even discourage, the Medicare supplemental insurance market in the private sector. Nearly 70 percent of Medicare's 28.4 million beneficiaries currently purchase supplemental policies (medigap insurance), many of which provide coverage for health care costs similar to or better than the expanded entitlement program in the Committee's bill. Given that another eight percent of beneficiaries are also eligible for Medicaid, which assists low-income elderly by meeting virtually all of their acute care health costs, there remain only five million beneficiaries who are currently without medigap or Medicaid coverage. Of these five million beneficiaries, fewer than 12,000 can expect to incure hospital stays longer than the 150 day limit currently contained in the Medicare program.

This leads to a critical question which a number of us feel was insufficiently discussed by the Committee: Should the government

be spending an additional five billion dollars a year to provide for so few of Medicare's beneficiaries?

Several of us feel that the Medicare catastrophic proposal contained in H.R. 2470 undermines the Medigap market by eliminating the most insurable risks from the market. At the same time, many of us feel that it is not likely that the Medigap insurers then will cover those expenses not covered in the proposals, such as drugs, eyeglasses, dental, or other services, which neither Medigap policies nor Medicare now cover.

In addition, a number of us would like to point out that four to five million Americans now have comprehensive medical coverage, with both Medicare and retiree health "benefits" from their employers. Many of them do not currently pay even Part B premiums. While these Medicare beneficiaries will receive no enhanced coverage from the Committee proposal, those elderly with taxable income, under the financing mechanism, will be forced to pay surtaxes for benefits for which they already have paid through private insurance coverage. The result will be greater reliance on the government benefits as these elderly accept enhanced Part B coverage for which they would now mostly be paying in the form of surtaxes.

The second of the President's guidelines also cautions that "we should not encourage excessive use of services." However, many of us are quite skeptical whether this bill contains adequate safeguards to prevent over-utilization. One need look only at the projected growth rates of the expansion of benefits beyond the acute care provision to see the huge potential for over-utilization. Over the first five years of the expansion of benefits, spending on the new mental health benefit will grow 55%, spending on the new home health benefit will increase 76%, and spending on the new skilled nursing facility benefit will increase 136%. In addition, many of us feel that the Part B cap of $1,000 will add "fuel to the fire" of the fastest growing segment of the Medicare program, physician payment. If Medicare begins to pay 100% of the allowed charges after the first $1,000, SMI trust fund expenditures could grow even more rapidly than the current 15.3% growth this year and 30% growth projected over the past four years. About 2.5% of the increase in physician payments is due to a higher than expected volume in services, a phenomenon unexplained by the expanding population of Medicare beneficiaries. Many of us feel that the low cap likely will add an incentive to provide even more tests and procedures.

In regard to the third guideline set by the President, that "any catastrophic illness coverage should be voluntary, not a new government entitlement," many of us feel that provisions in the Committee reported bill are clearly new entitlements. H.R. 2470 entitles all Medicare beneficiaries to unlimited inpatient hospital stays, expands the current entitlement of 100 days of skilled nursing facility care per spell of illness to 150 days per year, and expands the current entitlement for hospice care. While the bill provides Medicare catastrophic coverage for those persons voluntarily enrolling in Part B, many of us would like to note that this bill does not give those individuals who enroll in Part B (about 97% of Medicare beneficiaries) the option of accepting this additional coverage.

Thus, for those enrolled in Part B, but covered by private insurance for acute catastrophic expenses (about 65.4% of the elderly), this can be seen as an unnecessary new entitlement program. Furthermore, it is disturbing to several of us to find that the financing mechanism, in that it levies a surtax on all the elderly who have taxable income, forces those individuals who do not enroll in Part B, but who have taxable income, to pay for the benefits which they will never receive.

As concerns the fourth and final guideline of the President, that the proposal remain fully budget-neutral, many of us feel that the bill threatens to be a budget buster. As stated earlier, we are concerned with the lack of actuarial estimates available to the Committee as to whether or not the acute care benefit will be budget neutral beyond the first five years of the program.

During the Committee mark-up, the Health Care Financing Administration actuary testified that, given the original financing proposal (including in taxable income the actuarial value of the Part A and Part B benefits), the new program would have a $10 billion revenue shortfall in the year 2000, worsening to a $30 billion revenue shortfall by the year 2005. Given the currently projected depletion date of the Medicare Trust Funds (2002, under the Medicare Trustee's intermediate economic assumptions), these figures certainly cause many of us to question whether the Committee has taken the proper safeguards to prevent this expansion of the Medicare program from threatening the program's very existence. While the Subcommittee-reported financing was replaced by a premium and surtax formula, we do not believe that there has been adequate evidence available to show that this new funding method will ensure that this new entitlement program will remain budget neutral. Preliminary estimates by the Department of Treasury, using the Medicare actuaries' alternative II–B assumptions, show that the average cost per Medicare enrollee of the Committee's proposal is approximately $150 per enrollee in 1989. By the year 2005, if the program is to remain budget neutral, this average cost will have grown to be somewhere between $800 to $1000 per enrollee, and this is in 1988 dollars! In addition, the Treasury Department estimates that, by the year 2005, the $1700 cap on out-of-pocket costs will have risen to between $3000 and $4000, again in 1988 dollars. Furthermore, the Treasury Department estimates that this program, which in 1989 will represent about 5% of the Medicare program costs, will grow to be about 10% of the Medicare program in the year 2005. Certainly, these figures warrant a far greater consideration of the long-term potential for explosive costs than the few minutes which was given by the Committee.

It is clear to us that the Committee proposal conflicts with many of the guidelines set by the President for the catastrophic illness insurance program. We do not wish to see an expansion of Medicare which theatens the very financial security of the system itself. We also do not wish to see a bill which misleads the elderly into believing that all their retirement health needs beyond an out-of-pocket cap will be taken care of by the national government. In addition, we certainly question the wisdom of replacing the private insurance market with a new federal government program. Furthermore, we are opposed to the involuntary nature of this pro-

gram. Also, we are quite wary of the projected increases of the mandatory progressive surtaxes levied upon certain sectors of the elderly population. For the reasons cited here and many more, we cannot support H.R. 2470, as reported by the Committee on Ways and Means, in its current form.

BILL ARCHER.
HAL DAUB
HANK BROWN.
PHIL CRANE.
RICHARD SCHULZE.
JUDD GREGG.

VIII. ADDITIONAL DISSENTING VIEWS

ADDITIONAL DISSENTING VIEWS OF THE HONORABLE HAL DAUB

The time has certainly come for Congress to reexamine the Medicare Program and to address the changing needs of our Nation's senior citizens. Efforts to provide protection against catastrophic health care costs are commendable; however, I am concerned that the committee's bill, H.R. 2470, "The Medicare Catastrophic Protection Act of 1987," will perpetuate the myth among many of the elderly that Medicare covers all the costs of illness, whether acute medical or longterm care expenses. The title of the bill is certainly a misnomer. The legislation does not "close" all of the gaps that now exist in Medicare coverage.

My greatest concern is that H.R. 2470 fails to protect the elderly sufficiently against what I believe to be the most devastating catastrophic expenses—namely, those associated with longterm care. In testimony before the Ways and Means Health Subcommittee, representatives of various senior groups have attested to the fact that the greatest deficiency in the present health care system is the lack of a longterm care system encompassing medical, social, and personal care services provided in a variety of community, home-based, and non-institutional settings.

I have authored legislation, H.R. 1776, "The Longterm Health Care Amendments of 1987," which addresses these critical issues now facing our elderly population, and which offers incentives for the working-age population so that they may begin to provide for their future health care needs.

My legislation incorporates a balance of governmental, individual, and employer incentives that begin to build those reserves that will be necessary to adequately fund any longterm care program. There is no doubt that the provision of longterm care benefits—whether it be through a government program or via the establishment of individual insurance incentives—will be a costly proposition. Considering, though, that the committee's bill, H.R. 2470, will expend $25 billion over the next five years, I strongly believe that these funds would be more appropriately spent in the longterm care area.

The definition of "catastrophic illness" alone can be interpreted in many ways, depending upon where one sees the greatest demand for need. I am convinced that our senior citizen's catastrophic costs arise from those costs associated with longterm care.

The committee had a real opportunity to address some very critical health policy issues, but missed the mark. I cannot support H.R. 2470 in its present form.

HAL DAUB.

ADDITIONAL DISSENTING VIEWS OF THE HONORABLE JUDD GREGG

Clearly, the time has come to consider Medicare coverage for catastrophic illness. No one should have to live with the fear that a long hospital stay could drain a lifetime of savings. The question before Congress, then, is not whether we should reevaluate the adequacy of the current Medicare benefit but, more appropriately: HOW should we approach this challenge? The Committee on Ways and Means was presented with two basic approaches to the issue of Medicare coverage for catastrophic illness: H.R. 2470, the Stark-Gradison "Catastrophic Protection Act of 1987" and H.R. 1245, President Reagan's initiative, "The Medicare Catastrophic Illness Coverage Act." In approving H.R. 2470 and rejecting H.R. 1245, the Committee has issued a shortsighted and fiscally unsound response to the long-range health care needs of our senior citizens.

The President's initiative, H.R. 1245, makes some much-needed changes in the Medicare system, is actuarially sound and costs one-half the price of H.R. 2470. Consequently, it is a much more appropriate and fiscally responsible approach to the issue of Medicare coverage for catastrophic illness. Furthermore, H.R. 1245 does not contain many of the serious policy implications found in H.R. 2470. First, actuaries at the Department of Health and Human Services project that the Stark-Gradison benefits package could drain the Medicare Trust Funds by as much as $10 billion in the year 2000, and $30 billion in the year 2005. Using moderate economic forecasts, we can expect the Hospital Insurance Trust Fund to run deficits of $1.6 billion as early as 1995. By the year 2002, the fund will be insolvent and will have deficits of as much as $32 billion. Paying for current benefits will be difficult enough given the problems of an already grossly underfunded program. H.R. 2470 will make a bad situation much worse; H.R. 1245 will not.

A second problem with the Stark-Gradison plan is the fact that, to a great extent, what is being delivered is a replacement of private insurance. Today, 70% of senior citizens are covered for high out-of-pocket expenses by Medicare supplemental policies. Medicaid provides coverage for another 10% of the population over 65. In an HIAA survey of top commercial Medigap policies, 86% of insureds were covered for 100% of all Medicare allowable hospital expenses, 92% were covered for the Part A hospital deductible and 93% had unlimited coverage for Medicare allowable Part B expenses. Stark-Gradison, then, at a cost of $24 billion, gives additional coverage to only a small percentage of people, while essentially socializing an entire area of health care that is now being satisfactorily handled by the private sector. Scarce federal resources are being misapplied and, rather than encouraging the private sector to bear some of the costs of the insurance, we are actually replacing private dollars with federal tax dollars.

Third, one must wonder at the arbitrary and unrealistic definition of "catastrophic cost" imposed by Stark-Gradison. Clearly, there is a need for insurance coverage, in some cases even federal coverage, for extremely expensive health care services, where private sector activity is insufficient. But is $1500 truly catastrophic, particularly in view of the fact that many low-income seniors qualify for Medicaid which offsets a large portion of the $1500? If we are to consider $1500 in health care costs to be catastrophic, how do we view the $4410 spent annually by the average elderly household for shelter or the $2372 food cost and $2246 transportation cost encountered each year by the average senior citizen? Why Congress is so rigid in adhering to an arbitrary definition of "catastrophic" when the costs are so high and the benefits so misdirected is incomprehensible.

In truth, H.R. 1245, not H.R. 2470, is the best approach to Medicare coverage for catastrophic illness. The President's initiative accomplishes a worthy goal of restructuring the current Medicare acute care benefit, and is a clear and definite improvement over the present system. It does not contain benefits that will raid the already fragile Medicare Trust Funds or sprial in the out-years. Unlike H.R. 2470, which indexes its catastrophic cap to the Social Security COLA, H.R. 1245 indexes its cap to Medicare inflation, thus guaranteering costs to increase at a slower, more predictable pace. H.R. 1245, at a five-year cost of $12 billion, provides beneficiaries with added acute care protection but, unlike Strak-Gradison, does not spend $24 billion dollars in the process.

Finally, H.R. 1245 does not raid the pockets of beneficiaries. It does not cut off future revenue sources for other burdensome, often catastrophic, out-of-pocket costs incurred by the elderly: balance billing, dental and eye care, and most importantly, long-term care. Under H.R. 2470, some beneficiaries who are now paying $214.80 annually for their Medicare Part B coverage (which in 1965 was $36 annually) would be required to pay as much as $1,265.000 in 1992, an increase of 590%. It is clearly unfair to make some individuals pay almost six times what they are paying now for a benefit that is very likely already being covered by private Medicare supplemental policies. An income-related supplemental premium approach could easily be applied to H.R. 1245 to require those who can afford to pay more to do so, at generally less cost than under H.R. 2470.

In summary, the major difference between H.R. 1245 and H.R. 2470 is the fact that H.R. 1245 addresses problems and H.R. 2470 creates them. In the frenzy to provide new benefits, few are considering priorities or worrying about uncontrollable costs. The creation of huge deficits in the Medicare Trust Funds in the out-years, the failure to leverage private dollars with federal dollars, and the misguided replacement of private sector involvement with federal programs most certainly should not be the doctrine at the heart of this federal initiative or those to come. It is unfortunate that the Committee could not recognize this and be more receptive to a plan which does not result in a $24 billion dollars catastrophe.

JUDD GREGG.

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